

**DEVELOPING AND TESTING OF CULTURALLY ADAPTED  
CBT (CaCBT) FOR COMMON MENTAL DISORDERS OF  
PASHTO SPEAKING PAKISTANIS AND AFGHANS**

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**PhD Thesis to obtain the PhD Degree in Medicine;  
Specialization: Mental Health**

**July, 2016**

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## **DEDICATION**

*I dedicate this effort to my Family, Friends and Teachers  
for their continuous support and trust in my abilities  
and for showing great love & affection.*



## **ACKNOWLEDGEMENT**

All praise is to Almighty Allah for enabling me to conceive the idea, utilize the opportunity and courage to accomplish this study. I am extremely grateful to Prof. Dr. Jose Miguel Caldas de Almeida for supervising and critically reviewing the research work and his support throughout the project.

I must acknowledge Prof. Dr. Farooq Naeem whose pioneering work in this field inspired me and I have taken a lot of help from his research projects. His guidance and encouragement made it easy for me to complete this project.

I also wish to thank Dr. Imran Khan, Dr. Urooj Saleem, Mifrah Rauf Sethi and Marina Duffy for helping at various stages of this research project. They have made life easier for me during the course of this research.

This work could not have been possible without the help of Dr. Naila Riaz Awan. I cannot express my gratitude for her. She has worked day and night to make this project a success. Hats off to her.

For showing special interest in whatever I do and encouraging me throughout, I feel that my whole family deserves special acknowledgement.

Dr. Muhammad Irfan

## **LIST OF ABBREVIATIONS**

BSI	Bradford Somatic Inventory
CaCBT	Culturally Adapted Cognitive Behaviour Therapy
CBT	Cognitive Behaviour Therapy
CMD	Common Mental Disorders
DALY	Disability Adjusted Life Years
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders
GBD	Global Burden of Disease
GHQ	General Health Questionnaire
GP	General Practitioner
HADS	Hospital Anxiety and Depression Scale
ICD-10	International Classification of Disease-10
NICE	National Institute of Clinical Excellence
RCT	Randomized Controlled Trial
SOS	Schwartz Outcome Scale
SPSS	Statistical Package for Social Sciences
TAU	Treatment As Usual
WHO	World Health Organization
WHO DAS	World Health Organization – Disability Assessment Scale
YLD	Years Lived with Disabilities

## **INTRODUCTION**

This thesis carried out between January 2015 and July 2016, describes the process of adaptation of cognitive behaviour therapy (CBT) for common mental disorders (CMDs) and evaluation of its effectiveness through a pilot project in Pashto-speaking Khyber Pakhtunkhwa and FATA area of Pakistan and Afghanistan. This region has faced multiple traumas and difficulties including severe floods, earthquakes, Pak-Afghan-Russian war (1979-1989), the burden of Afghan refugees in Pakistan, civil war in Afghanistan, as well as terrorist attacks and bombing in the aftermath of 9/11. This brought destruction to the region and the rates of mental health problems, especially CMDs are considered to be fairly high in this region. Adapting a cost-effective intervention such as CBT, which is an effective treatment for the treatment of CMDs, might, therefore, be of enormous help in reducing CMDs in the region. However, CBT would need adapting for its use in non-western cultures.

This thesis is divided into 12 chapters. The first chapter gives an overview of the problem, i.e. CMDs around the globe. This chapter includes Prevalence, Risk Factors, Presentation and Aetiology of CMDs and moves on to focusing on different treatment options. Chapter 2 describes CBT with the emphasis on its use in CMDs. Since CBT was developed in the west (as

highlighted in Chapter 2) and therefore might have been heavily influenced by the underlying cultural values, Chapter 3 discusses the link between culture and CBT. This chapter also encompasses discussion on Sufism (Islamic version of mindfulness). The next two chapters focus on mental health in the region under study in general but CMDs in specific. Chapter 4 describes health system of the region, the state of mental health as well as traditional healing practices in the region, while chapter 5 discusses current status of CMDs in the region.

Chapter 6 is an introduction to the project which discusses the need for the project, methodology used, the reasons for choosing CBT, and a brief description of qualitative methods to be used. Chapter 7 describes the beginning of the qualitative research of the study. It describes exploration of the patients' views about their illness and its treatment and to see what they think about CBT. A similar approach is used in Chapter 8 to explore the views of the carers about the illness and treatment of their patients. Chapter 9 describes the interviews with the mental health professionals. It also highlights the methods adopted and the results of the qualitative analyses, similar to Chapter 7 and 8. It was also considered necessary to translate the terminologies used in CBT and for this, students were interviewed. This is described in Chapter 10. On the basis of all the qualitative work, we developed a study manual and Chapter 11 describes

the pilot project which was conducted to assess the effectiveness of the adapted therapy based on the manual prepared for patients with CMDs, using a Randomized Controlled Trial (RCT) design.

The final chapter (chapter 12), summarizes the thesis and discusses some of the key findings. It also describes the lessons learnt from this project and elaborates the way forward for implementation of culturally adapted CBT in the region.

## **CHAPTER 1: COMMON MENTAL DISORDERS (CMDs)**

Common mental disorders (CMDs) are defined as “a group of distress states resulting in anxiety, depressive and unexplained somatic symptoms”<sup>1, 2</sup>. They are the leading cause of mental health disability according to the World Health Organization (WHO) Global Burden of Disease (GBD)<sup>3</sup>. Those suffering from socio-economic deprivation and marginalisation are consistently shown at greater risk of these disorders in cross-sectional population-based studies<sup>4</sup>. There is a high comorbidity of somatoform disorders with anxiety and depressive disorders<sup>5</sup>, and the burden of illness may be considerable<sup>6</sup>. These disorders present either alone or may be accompanied by one or more physical disorders. From a population perspective developed or developing countries show no substantial differences in the prevalence of these disorders.

Analysis of the GBD shows that unipolar depressive disorder (one of the CMDs) is the 4<sup>th</sup> leading cause of burden among all diseases, accounting for 4.4% of the total Disability Adjusted Life Years (DALYs) and 11.9% of total years lived with disabilities (YLD)<sup>7, 8</sup>. With the same demographic trend, by the year 2020, the burden of depressive illness will increase to 5.7% of the total burden of disease, becoming the 2<sup>nd</sup> leading cause of DALYs lost<sup>3</sup>. Worldwide it will be second only to ischemic heart disease

for DALYs lost for both sexes. In the developed regions, depression will then be the highest ranking cause of burden of disease<sup>3, 8</sup>. According to the World Development Report, depressive illness ranks fifth among women and seventh among men as a cause of morbidity<sup>9</sup>.

In line with other recent trials of the WHO, we have focused on Anxiety and Depressive disorders while referring to CMDs<sup>10</sup>.

## **1.1 Prevalence of CMDs**

At any given time up to 15% of the population may be affected by common mental health disorders<sup>11</sup>. Worldwide 480 million people are estimated to be suffering from depression with a quarter of this number with a dual diagnosis of anxiety<sup>12</sup>.

### **1.1.1 Prevalence of Anxiety Disorders**

Globally the findings of epidemiological studies show that anxiety disorders are highly prevalent, common in all regions of the world and a significant cause of functional impairment<sup>13</sup>. 18.1% of adults in the United States are affected by Anxiety Disorders<sup>14</sup> with 13.6% reported in Europe<sup>13.6%</sup><sup>15</sup>. However, it is suggested that this number is much more significant and closer to 30% considering many people do not seek help, are misdiagnosed, or do not acknowledge themselves as having issues with anxiety. Women are twice as likely to be effected as men and it is very likely there is a co-

existence with other disorders<sup>16</sup>. In Canada, the 12-month prevalence of any anxiety disorder is over 12%<sup>17</sup> and approximately 14 % of Australians will be affected by an anxiety disorder in any 12 month period<sup>18</sup>.

### **1.1.2 Prevalence of Depressive Disorders**

Findings from Epidemiological studies undertaken show that depressive illness rates vary across the world. In an international ten-country epidemiological study of the prevalence of depressive illness<sup>19</sup> it was found that, lifetime prevalence varied between 1.5% (in Taiwan) and 19% (in Beirut) with higher rates in females. Another study in 15 countries with 25916 participants, examined common psychological problems in primary care settings<sup>20</sup>. An ICD-10 psychiatric diagnosis was attributed to close to a quarter (24%) of the primary care attendees worldwide. “Current depressive episode” was the most common (10.4%) diagnosis, while depressive illness and anxiety were the most frequent co-morbid disorders. There were marked differences in the prevalence of depressive illness at different centres which were considered due to variation in the level of awareness, recognition for cultural issues, popular perceptions of the role of the doctor, and different pathways to care and health systems<sup>20-23</sup>.

A literature review of community studies of depressive illness in Europe showed one year prevalence of major depressive illness in Western



European countries to be around 5%. Depressive illness was also found to have very high rates of co-morbid disorders, both psychiatric and physical<sup>24</sup>.

In Australia, about 4% of people are expected to face a major depressive episode in a 12 months' period (5% women; 3% men)<sup>18</sup>. In Canada, major depressive episode's 12-month prevalence was 4.7%<sup>17</sup>.

## **1.2 Risk Factors for CMDs**

Studies have identified some risk factors that are associated with CMDs; these include lower socioeconomic status, poor reproductive health, gender disadvantage and physical ill-health<sup>1, 25, 26</sup>. Lower socio-economic status has been directly related to chronic medical illnesses, poor reproductive health, substance use disorders ultimately leading to CMDs<sup>4</sup>. Social and economic deprivation has been linked with mental and behavioural diseases in many studies, the combination of which can result in a vicious cycle of hardship<sup>4, 25</sup>. As compared to males, females were found to have two to three times more risk and the vulnerability factors leading to depression include low family support, low autonomy, low social integration and a higher degree of domestic and sexual violence<sup>1, 26</sup>.

Chronic physical illnesses can lead to the development of CMDs through direct effect on brain due to infection, cerebrovascular accidents, trauma,

degeneration or through the effect of disease burden or comorbidity <sup>27</sup>.

### **1.3 Presentation of CMD**

Amongst different ethnic groups, CMDs can present in various forms in the general practice. A study of CMD (depressive disorders, anxiety and somatic complaints) among primary care patients in the UK, compared three groups of patients speaking three different languages i.e., English, Gujarati or Urdu, respectively, on a standardised interview. Researchers completed the General Health Questionnaire (GHQ) and Illness Behaviour Questionnaire (IBQ)<sup>28</sup>. Their General Practitioners provided diagnoses of their physical and mental disorders. The Gujarati speaking patients perceived less anxiety and were more likely to attribute their complaints to physical causes and scored higher on the Hypochondriasis and Denial scales. Their General Practitioners rated them as less likely to have relevant physical or mental disorders. The Urdu speaking group was intermediate in most respects. Although the rates of somatization were higher in the two Asian groups, the overall levels of somatization appeared to be high even in the English speaking group<sup>28</sup>.

#### **1.3.1 Presentation of Anxiety Disorders**

Anxiety disorder is usually associated with fear, nervousness, apprehension, and panic, but may also involve symptoms pertaining to the cardiovascular,

respiratory, gastrointestinal, or nervous systems, individually or in combination<sup>29, 30</sup>. Significant impairment of daily life, sleep problems, headaches, are common; physical symptoms (such as tachycardia and tremor) are also not uncommon. Fatigue and difficulty concentrating may lead to troubles at work or home<sup>31, 32</sup>. In social anxiety, one feels self-conscious around people in school, work, and social situations, appears shy, avoidance of speaking up in work meetings, attending social gatherings, and dating. An individual desperately wants to be more socially active but fears he will appear nervous and cause embarrassment to himself<sup>33</sup>.

### **1.3.2 Presentation of Depressive Disorders**

An individual's cultural background is likely to impact whether depressive disorders will be expressed in psychological and emotional terms, or in physical terms<sup>34</sup>. According to the International Classification of Diseases (ICD 10)<sup>34</sup>, a depressive episode is characterized by; "depressed mood, loss of interest or pleasure in activities that are normally pleasurable, decreased energy or increased fatigability, loss of confidence and self-esteem, unreasonable feelings of self-reproach or excessive and inappropriate guilt, recurrent thoughts of death or suicide, or any suicidal behaviour, complaints or evidence of diminished ability to think or concentrate, change in psychomotor activity, with agitation or retardation and disturbance of sleep or appetite". According to severity, depressive episode may be classified

into mild, moderate or severe<sup>34</sup>.

Depressive disorders are experienced across culture types. However, the clinical presentation may vary considerably and even the recognized core symptoms may not be prominent in many cultures<sup>35</sup>. However, this is an area which needs careful analysis. The case of depressed patients presenting with somatic symptoms can be considered as an interesting example in this regard. Earlier theories of depressive disorders suggested that somatization, typically occurring in non-Western cultures, was the cultural equivalent of depressive disorders but new evidence is suggesting that globally, somatic symptoms are common presenting characteristics of depressive disorders<sup>28</sup>.

The WHO Collaborative Study on the Assessment of Depressive illness<sup>36</sup>, reported that the most common symptoms (75% of cases) across sites were sadness, joylessness, anxiety, tension etc. Somatic symptoms were most common in Teheran and least frequent in Montreal<sup>36</sup>.

A paper describing a sub-analysis of data from the “WHO Study on Psychological Problems in General Health Care” concluded that the frequency of somatic symptoms depends on how Somatization is defined<sup>37</sup>. In Eastern traditions of medicine (Chinese or Ayurvedic), a sharp distinction between the ‘mental’ and the ‘physical’ does not occur, which may be a

reason for such presentations<sup>38</sup>. Similarly, people from these cultures may be unable to distinguish between the emotions of anxiety, irritability and depressive disorders because they are predisposed to express distress in somatic terms<sup>39</sup>. The expression of depressive disorders by Korean immigrants in the USA was found to be in symbols or was physical<sup>40</sup>. This is due to allocation of symbolic functions to each body organ in Korean traditional medicine<sup>40</sup>. A study using focus group design with depressed Punjabi women in London<sup>41</sup> found that they recognized the English word ‘depressive illness’, but the older generation used terms such as “weight on my heart/mind”, or “pressure on the mind”. Symptoms of “gas” and “feelings of heat” were also identified, which are in accordance with traditional and Ayurvedic models of “hot and cold”. Studies from the Indian subcontinent report inconsistent results regarding the frequency of different symptoms of depressive disorders as well as of somatic symptoms<sup>42</sup>. A study from the Middle East exploring detection of depression found that Arab patients use a variety of physical metaphors to describe depressive disorders<sup>43</sup>. Another study from Dubai in which focus groups were conducted to identify terms and descriptions used for depressive disorders, reported that patients were more likely to associate depressive disorders with aches, pains and weakness than Western people<sup>44</sup>. The term ‘depressive disorder’ itself is absent from the languages of many cultures; it is rarely used in others or it is construed differently<sup>43, 45</sup>. In a nutshell,

understanding culturally appropriate expressions of distress is of paramount importance in providing psychotherapy<sup>21</sup>.

#### **1.4 Aetiology of CMDs**

For CMDs, definitive aetiology have not yet been determined. Following description is about probable aetiological mechanisms.

##### **1.4.1 Aetiology of Anxiety Disorders**

Anxiety disorders are considered to be due to disrupted modulation within the central nervous system involving several neurotransmitter systems including serotonergic and noradrenergic neurotransmitter systems. As anxiety symptoms respond to benzodiazepines, disruption of the gamma-aminobutyric acid (GABA) system has also been implicated<sup>46</sup>.

Environmental stressors, in addition to genetic predisposition, play a role in varying degrees, in developing of an anxiety disorder<sup>47</sup>. Heightened sensitivity in patients suffering from anxiety leads to diminished autonomic flexibility, which may be the result of defective central information processing in anxiety-prone persons<sup>48</sup>.

##### **1.4.2 Aetiology of Depressive Disorders**

Depressive disorders can be attributed to a complex interaction between

psychosocial and biological factors. Our current understanding of depressive disorders incorporates the genetic, biological, and psychosocial factors (cognition, personality, and gender) that correlate with, or predispose to, depressive disorders<sup>49</sup>.

Over the last few decades, many researchers studying depressive disorders have tried to search for biologic alterations in brain function, e.g., neurochemical abnormalities. Abnormal concentrations of many neurotransmitters and their metabolites in urine, plasma, and cerebrospinal fluid have been detected, including dysregulation of the Hypothalamic-Pituitary-Adrenal axis, elevated levels of Corticotrophin Releasing Factor, and abnormalities in second messenger systems and neuroimaging<sup>50-52</sup>.

“Monoamine hypothesis” which has been the prevailing hypothesis of the causation of depressive disorder, after more than four decades of research, has been found insufficient to explain the complex aetiology of depressive disorders<sup>53</sup>.

A critical shortcoming of the monoamine hypothesis is its neglect of psychosocial risk factors like stress whose effects on rats’ HPA axis, the gastrointestinal tract, and the immune system have long been well established<sup>54</sup>. Researchers have now gathered enough evidence that not only

brain function but perhaps anatomic structure, can be influenced by stress, its interpretation, and learning<sup>55</sup> and it has been said that depressive disorders can be the outcome of severe and prolonged stress<sup>56</sup>. It is worth mentioning that increased activity in the HPA axis in depressive disorders is considered as the “most venerable finding in all of the biological psychiatry”<sup>57, 58</sup>.

If stressful events are the initial contributing factor to most cases of depressive disorders, then why all people that face stressful events, become depressed? The answer might lie in the possibility that genetic, social and psychological factors act together in a person to predispose to, or protect against depressive disorders<sup>21</sup>.

The death of a loved one is a powerful life stressor. In fact, the level of emotional impact of grief is to an extent that the diagnosis of depressive disorders should not be made unless there are specific complications such as incapacity, psychosis, or suicidal thoughts<sup>59</sup>.

Past parental neglect, physical and sexual abuse and other forms of maltreatment are linked now with establishment of depressive disorders. Conversely, early experience with mild, non-traumatic stressors (such as gentle handling) may help to protect or “immunize” animals against severe



stress<sup>60</sup>. One prominent theory of depressive disorders stems from studies of learned helplessness in animals which describes that depressive disorders arise from a cognitive state of helplessness and entrapment<sup>61</sup>.

Responses to life events can also be linked to personality<sup>62</sup>. Neuroticism predisposes to anxiety and depressive disorders<sup>63</sup> while having an easy-going temperament, protects against depressive disorders<sup>64</sup>. Also, people with severe personality disorder are likely to have a history of early adversity or maltreatment<sup>65</sup>.

Gender differences have been well studied and it is now well established that major depressive disorder and dysthymia are more common among women than men<sup>19, 66</sup>. Understanding the gender-related difference is likely related to the interaction of biological and psychosocial factors, including differences in stressful life events as well as in personality of women, resulting in different neural responses to stress<sup>67</sup>. Research conducted in working-class neighbourhoods suggests that life stress combined with inadequate social support contributes to women's greater susceptibility to depressive symptoms<sup>68</sup>. Also, subtle sex-related differences in hemispheric processing of emotional material may further predispose women to experience emotional stressors more intensely<sup>69</sup>. Untreated psychiatric problems are likely to worsen at menopause but menopause is neither a risk

factor, nor associated with increased rates of depressive disorders<sup>70, 71</sup>. The increased risk for depressive disorders prenatally or after childbirth suggests a role for hormonal influences. Similarly, there is evidence to suggest stressful life events have a role too<sup>21</sup>.

Mood disorders tend to “run in families” and susceptibility to a depressive disorder is twofold to fourfold greater among the first-degree relatives of patients with mood disorder<sup>72</sup>. Twin studies suggest that heritability of depression is 37-40%<sup>73</sup>. Studies on monozygotic twins revealed an increased risk of mood disorders, compared to other people<sup>74, 75</sup>. Those people who have greater heritable risk, also appear more vulnerable to stressful life events<sup>76</sup>. Evidence strongly suggest that vulnerability to mood disorders may be associated with several genes distributed among various chromosomes<sup>77, 78</sup>. It has also been reported in the genetic studies that depression shares genetic risk factors with bipolar disorder and schizophrenia, although there are some risk genes which are unique to depression<sup>79</sup>. However, genetic influence might also be mediated by other factors, e.g. temperament.

In a nutshell, biological factors interacting with psychosocial and environmental factors are likely to account for greater susceptibility to depressive disorders<sup>21</sup>.

## **1.5 Disability associated with CMDs**

Disability is defined as "any restriction or lack of capacity to perform an activity in a manner or within a range considered normal for a human being"<sup>80</sup>. Epidemiological studies have shown an association of CMDs with functional disability<sup>81</sup>. Patients with CMDs show higher levels of disability as compared to patients without significant psychiatric symptoms. Studies conducted in primary care reported that chronic disability is experience in patients whose symptoms ran a chronic course<sup>81, 82</sup>.

## **1.6 Economic Burden of CMDs**

A survey conducted by WHO in 2010, reported 450 million persons worldwide to be suffering from mental or behavioral diseases posing a considerable societal and economic burden<sup>3</sup>.

### **1.6.1 Economic Burden of Anxiety Disorders**

Approximately 26.9 million individuals in the United States are estimated to get affected by Anxiety disorders during their lifetime. Almost 31.5% of total expenditures for mental illness was based on the costs associated with anxiety disorders in 1990, which is estimated to be around \$46.6 billion with more than three quarters attributable to lost or reduced productivity. Therefore, the economic burden of anxiety disorders can be reduced by

increasing the availability of effective, relatively low-cost outpatient treatment<sup>83</sup>.

The societal burden was estimated to be between \$42.3 to 46.6 billion in the U.S. in 1990<sup>83, 84</sup> and in a comparatively recent study in England in 2007, it was approximately GBP 1.2 billion<sup>85</sup>.

### **1.6.2 Economic Burden of Depressive Disorders**

A study which estimated the changes in economic burden of depressive disorders over time, and measured the economic burden of depressive disorders in Sweden from 1997 to 2005, measuring both the direct cost (providing health care to patients of depressive disorder) and the indirect costs (value of production lost due to morbidity or mortality), was conducted in a cost-of-illness framework<sup>86</sup>. The cost was estimated to be more than double, increasing from a total of Euro 1.7 billion in 1997 to Euro 3.5 billion in 2005. In 2005, direct costs were estimated to be 14% of the total (0.5 billion Euros) while 86% was the direct cost (3 billion Euros). The drugs cost was just 3% of the total cost (100 million Euros). The authors concluded that this makes depressive disorder to be a major public health concern for the patients, their carers and decision makers. In Japan, the cost of depression was JPY 2.0 trillion in 2005, which is equivalent to 18 billion USD<sup>87</sup>. It has been estimated that the total annual cost of depressive

disorders in Europe in 2004 was 118 billion Euro (253 Euro per inhabitant) with 42 billion Euro as direct and 76 billion Euro as indirect cost. With these figures, and accounting for 33% of the total cost, depressive disorders stand in Europe as the costliest brain disorder, corresponding to 1% of the total economy of Europe (GDP)<sup>86</sup>.

A systematic literature review looked into all “cost of illness” studies of depressive disorders published worldwide<sup>88</sup>. The average annual costs per case for direct costs ranged from \$1000 to \$2500, \$2000-3700 for morbidity and \$200-400 for mortality costs. However, the authors admitted that the study results were limited due to methodical differences which limited comparison substantially. Another literature review highlighted the problems in this area<sup>89</sup>. The authors suggested that there are to improvement at every level including patient, healthcare provider, practice, plan and purchase levels and that the effective treatment of depressive disorders can be cost effective because the cost per Quality Adjusted Life Years associated with improved depressive disorders has been shown to start as low as \$ 2519 and may go as high as \$ 49500<sup>21</sup>.

### **1.7 Emergency associated with CMDs - Suicide**

Suicide is the most catastrophic outcome of CMDs. Its association with psychopathology has been comprehensively explored. Among the

psychiatric diagnoses associated with suicide, depressive illness is considered to be most important<sup>90</sup>. It has been suggested that the lifetime rates of suicidal attempts vary across cultures<sup>36</sup>. The prevalence of deaths due to suicide is lower in Central and South American countries compared to East European countries while the rates are in the middle range in the US, Western Europe and Asia<sup>91</sup>. According to DALY, in 1998, suicide was responsible for 1.8% of the total impact of diseases worldwide (1.7% in developing up to 2.3% in developed countries)<sup>90</sup>. The epidemiological survey of the Multisite Intervention Study on Suicide Behaviour (SUPRE-MISS) interviewed individuals from eight cities around the globe and found great variations among the centers in Suicidal ideation (2.6-25.4%), suicide planning (1.1-15.6%) and suicide attempts (0.4-4.2%). Suicidal ideation was more frequent in women, in young adults, in those who don't live with their family, and in those with mental disorders especially symptoms of depressive illness symptoms (lack of energy and depressed mood)<sup>92</sup>.

There is a consensus among researchers in sociology that, there is no single factor contributable to the cause of suicide attempts. The risk factors extensively studied till date are previous suicide attempts, genetic factors, social and familial support, and psychopathology<sup>93</sup>. Historically, psychological theories have tried to understand the factors responsible for suicide and the situations which become the precursor for the act of suicide

but these all have theories have their own interpretations with some commonalities and differences<sup>94-97</sup>. However, population-based surveys in the US, Canada and urban China indicate that depressive illness is the main entity associated with suicide attempts, suicidal ideation, and suicide plans<sup>90</sup>. It has been reported that the diagnosis of major depressive illness was associated with a nearly ten-fold odds ratio, as compared to anxiety disorder<sup>98</sup>. In another study in Montreal, depressive illness was the commonest Axis I diagnosis<sup>99</sup>. In a study, using an innovative data collection strategy (Life Trajectory Instrument), in association with suicide, the diagnosis of depressive illness was the most found (66%), followed by substance use disorder (59%)<sup>100</sup>.

There is well established significance of co-morbidity in increasing the suicide risk. One Finnish study of psychological autopsy in 229 suicides found that the most prevalent disorders were depressive illness (59%) and alcohol dependence or abuse (43%) and only few of those considered as depressed were receiving adequate treatment for depressive illness<sup>101</sup>. The findings have suggested that men who suffer from depressive illness seek less help, are less frequently diagnosed as depressive disorder and receive fewer treatments, besides complying less with the treatments<sup>102</sup>. Among the depressed, the chance of death by suicide is increased by drug dependence, panic attacks, severe anxiety, restlessness, and insomnia<sup>103</sup>. It is worth

mentioning that it has been demonstrated in a study with patients of panic disorder that anxiety disorder alone was not associated with suicidality, but those with co-morbid depressive illness showed significantly higher association of suicidal intention and behaviour<sup>104</sup>.

A meta-analysis on suicide and psychiatric diagnoses showed that 87.3% (43.2% showed mood disorder) showed at least one psychiatric diagnosis prior to suicide<sup>105</sup>. Another study exploring the temporal relation between suicide and depressive illness showed that 74.4% of suicides were associated with the first episode, 18.8% with the second episode and 6.5% were associated with more than two episodes of major depressive illness<sup>106</sup>. One case-control study has reported that depressive symptoms (lack of energy and depressed mood) were regularly associated with suicidal ideation<sup>107</sup>.

It is important to note that although the great majority of individuals committing suicide have some psychiatric illness, approximately 10% of those who commit suicide do not have psychiatric diagnoses<sup>90</sup>. A case-control study, however, has suggested that psychopathological traits have an outstanding role in suicide cases, even in cases apparently free of major psychiatric diseases<sup>90, 108</sup>.



## **1.8 Management of CMDs**

A bio-psycho-social model is used to manage CMDs. The model assumes that the causes of these disorders can be physical, psychological and social. Consequently, the common causes include; genetic predisposition, problems in early development (e.g., parental discord in childhood and childhood abuse), personality traits (for example, obsessional and anxious dependent personality traits) and environmental factors, such as recent stressful life events and lack of social support. The first and the most essential step in the management of CMDs is assessment. History taking and examination of the mental and physical state form the assessment. Assessment is however an ongoing process and never ends<sup>21</sup>.

### **1.8.1 Assessment of CMDs**

The assessment should commence with a focused history. This is a part of psychiatric interview which apart from history taking, takes into account personality profile that may suggest adaptive (e.g., resilience, conscientiousness) or maladaptive (e.g., self-centeredness, dependency, poor tolerance of frustration) traits. The interview may determine whether distress is expressed in physical symptoms (e.g., headache, abdominal pain), mental symptoms (e.g., phobic behaviour, depressive illness), or social behaviour (e.g., withdrawal, rebelliousness). The attitudes of patients regarding psychiatric treatments, including pharmacotherapy and

psychotherapy, should also be noted. However, some of these aspects might vary across cultures, for example, reduced eye contact in an Asian patient might be due to respect for the doctor<sup>21</sup>.

Diagnosis is an important part of the assessment. Although, several brief questionnaires are also available for screening, the diagnosis should be based on symptoms required by ICD10 or DSM-IV criteria for diagnosis of CMDs<sup>59, 109</sup>.

There are no laboratory findings which are pathognomonic of CMDs. These tests include thyrotropin-releasing hormone stimulation test, dexamethasone suppression test, and sleep EEG for rapid eye movement latency are rarely indicated or helpful. PET scanning may show a change in brain metabolism of glucose in the dorsal frontal lobes where it is decreased and in the amygdala, cingulate, and subgenual cortex where it is increased. In essence, laboratory testing is necessary to exclude physical conditions that can cause CMDs. For these tests like Complete Blood Picture, thyroid-stimulating hormone levels, serum electrolyte, vitamin B12, and folate levels are conducted. Sometimes, testing urine for drug screen is appropriate. Always consider organic causes like hypothyroidism, hyperthyroidism, Parkinson's disease etc. in mind while assessing these patients and a thorough neurologic examination is needed to exclude this disorder<sup>21</sup>.

Figure 1.1 summarizes the process of assessment for suspected patients of CMDs.

**Figure 1.1: Assessment of CMDs**

- “Full history and examination - consider organic causes of CMDs, e.g., hypoglycaemia; hyper- or hypothyroidism, pan-hypo-pituitarism, cardiac disorders; chronic respiratory disease; vitamin B deficiency; drug abuse etc.
- Assess the safety of patient to self and others - they may need to be admitted (voluntarily or as per the Mental Health Act).
- Consider whether the patient needs to have treatment in secondary care, e.g., severe depression, depression with psychosis, etc.
- Assess suicidal intent at regular intervals.
- Involve patients and family members (if patient's consent). One needs to consider patients' cultural background and social circumstances.
- Treatment of CMDs needs to be multidisciplinary. This involves a combination of medication, psychotherapeutic and psychosocial interventions, e.g., self-help and support groups.”

Assessment for features of specific disorder as well as other coexisting psychiatric disorders should be considered if there is no evidence of a medical cause for the patient's symptoms<sup>110</sup>.

Once the initial assessment has been carried out, the first decision a clinician has to make is whether the patient requires in-patient or out-patient

care. If the patient has no insight into his illness, assessment under the Mental Health Ordinance is considered<sup>111</sup>. Assessment of severity of CMDs can also help us in choosing the appropriate treatment. In this chapter we will only briefly look at the commonly used treatments.

### **1.8.2 Pharmacological Management of CMDs**

The main stay of pharmacological management of CMDs is Selective serotonin reuptake inhibitors (SSRIs).

#### **1.8.2.1 Pharmacological Management of Anxiety Disorders**

The first line pharmacological agents for the treatment of anxiety disorders are Selective serotonin reuptake inhibitors (SSRIs) and serotonin noradrenaline reuptake inhibitors (SNRIs)<sup>112</sup>. For panic disorders, Benzodiazepines are used and for Generalized anxiety disorders (GAD) benzodiazepines and Azapirones are used<sup>113-116</sup>. Benzodiazepines should be used for short term i.e., up to four weeks because its chronic use can lead to tolerance, dependence, withdrawal, relapse, rebound, interactions with other medications and adverse events<sup>113-115</sup>. Tricyclic antidepressants (TCA) and monoamine oxidase (MAO) inhibitors, and the use of anticonvulsants and atypical antipsychotics as adjuncts, may be considered in treatment resistant cases<sup>112</sup>. As far as a combination of pharmacotherapy and psychotherapies especially CBT is concerned, the combination, in the long term, has not

been found to be superior to either treatment alone<sup>117, 118</sup>. Some researchers consider the concurrent use of CBT and anxiolytic medications to be detrimental to the extinction phase of exposure based therapies<sup>119</sup>. Patients in the west consider CBT to be more effective in the long term<sup>120, 121</sup>. However, patient characteristics and preferences must be given importance in clinical decision making, considering local circumstances.

#### **1.8.2.2 Pharmacological Management of Depressive Disorders**

For the pharmacological management of depressive disorders, SSRIs, SNRIs, TCAs and MAO inhibitors are used but the choice to use any particular antidepressant medication needs to be made according to the requirement of the individual patient, with particular consideration of likely side effects<sup>122</sup>. A variety of drugs are used for treating co-morbid psychiatric disorders or resistant cases of depressive disorders.

About half of moderate-to-severe cases of depressive disorders need antidepressants for improvement<sup>123</sup>. Among various available SSRIs or between SSRIs and other classes of antidepressants, researches have shown little difference in efficacy or tolerability<sup>123</sup>. SSRIs can be helpful in patients who do not respond to TCA and appear to be better tolerated with lower rates of discontinuation<sup>124</sup>. However, TCA may have greater efficacy than SSRIs in severe major depressive disorders or depressive disorders with

melancholic features<sup>125</sup>. For depressive disorders in which physical symptoms or pain is prominent, SSRIs are considered to be less effective<sup>126</sup>. Fluoxetine has consistently been shown to be effective in children and adolescents<sup>127</sup>, and overall, SSRIs may be superior to SNRIs in young adults (18 to 24 years)<sup>128</sup>.

The continuation phase, generally lasts between 6 to 9 months after the induction of remission<sup>129</sup>. Continuation phase of a year is required for episodes lasting more than 6 months and/ or having psychotic features<sup>130</sup>. Gradual discontinuation may be planned for most patients after at least six months of treatment, if there is no recurrence or relapse during continuation therapy. As compared with continuation treatment, early discontinuation is associated with a 77 % higher risk of relapse<sup>131</sup>. The tapering of medication minimizes the chances of discontinuation syndrome<sup>132</sup>.

The duration of maintenance treatment depends on the natural history of the illness and maintenance treatment for 12 to 36 months reduces the risk of recurrence by two thirds<sup>133</sup>. Antidepressant that brought about remission is considered to be the first choice of medication for the maintenance phase and all classes of antidepressants have been proven to be helpful<sup>134, 135</sup>. Patient and family education reduces treatment attrition and improves the outcome<sup>122</sup>.

### **1.8.3 Electroconvulsive Therapy (ECT)**

The remission rates with ECT are 60-80% in severe depressive disorders, though lower success rates are reported in community settings<sup>136</sup>. ECT can be a first-line treatment for patients who have severe depressive disorder with psychotic features, psychomotor retardation, or medication resistance and for those who are suicidal or pregnant<sup>134</sup>. A course of ECT usually consists of 6 to 12 treatments, is administered twice or thrice a week, preferably by an experienced psychiatrist. transient post-ictal confusion and anterograde and retrograde memory impairment are the common side effects; the latter generally improves in days or weeks<sup>137</sup>. After ECT, because the relapse rate is more than 50 percent, it is mandatory to start prophylactic treatment with an antidepressant medication combined with an augmenting medication, if needed<sup>138</sup>.

### **1.8.4 Psychological Management of CMDs**

Various forms of psychological approaches have been shown to be effective for CMDs. These include Counseling, behavioural approach, cognitive approach, Problem solving therapy, Psychodynamic psychotherapy, Interpersonal therapy and CBT.

#### **1.8.4.1 Psychological Management of Anxiety Disorders**

When dealing with someone with an anxiety disorder, it is important to psycho-educate patient about the nature and presentation of anxiety. GPs are an important source of psychoeducation to patients, as they are a trusted and authoritative figure<sup>110</sup>.

Psychological treatments, especially CBT, have been shown to be at least as effective as medication for anxiety disorders,<sup>121, 139</sup> although a great majority of young people, due to lack of awareness and appropriate local services, competing family time commitments, and a paucity of trained professionals, do not access clinical services<sup>140</sup>. Therefore, recent therapeutic innovations have focused on brief or low-intensity versions of CBT that can be delivered by non-specialists, with the ultimate aim of delivering treatment within a stepped-care framework<sup>141</sup>. Intensive treatment is reserved for non-responders to the first-line treatment<sup>142</sup>.

#### **1.8.4.2 Psychological Management of Depressive Disorders**

The need for psychological intervention needs to be considered in every case. Although antidepressant drugs are less expensive than psychotherapy in the short term, some depressed patients don't respond to medication. Similarly, some patients might refuse to take medicines because of personal reasons or side effects. All depressed patients require support,



encouragement, and a thorough explanation that they are suffering from illness and not moral failure. Similarly, counselling of spouses and family members is often required. Psychotherapies mainly used for depressive patients include: supportive psychotherapy, dynamic psychotherapy, interpersonal psychotherapy (IPT), marital therapy, and CBT. The kind of psychotherapy used depends largely on the availability of a suitably trained therapist and the preference of the patients; even though more structured therapies such as IPT and CBT have greater efficacy in the treatment of depressive disorders<sup>21</sup>.

IPT is a standardized treatment approach to life and personal relationship problems. In an important multicenter trial, involving 240 out-patients, IPT was compared with cognitive therapy, Imipramine with case management and placebo with clinical management. Most patients had improved after 16 weeks. In the patient groups as a whole there were few significant differences between the treatments; Imipramine was somewhat more effective, as was IPT, but to a lesser extent. When patients with more severe depressive disorders were considered separately, Imipramine was consistently better than placebo and clinical management, while IPT was almost as effective as Imipramine<sup>143</sup>. One recent study however, found CBT to be as effective as IPT for mild and moderate cases, however CBT was more effective than IPT for severe depressive disorders<sup>144</sup>.

CBT originally incorporated techniques from cognitive therapy and behaviour therapy. CBT, however, has evolved during the last 50 years and is probably the most widely practiced form of psychotherapy these days in Western Europe and North America. The results of clinical trials indicate that for moderate severity the effect of CBT is about equal to those of antidepressant drug treatment<sup>145</sup>. In the National Institute of Mental Health (NIMH) study mentioned above<sup>143</sup>, cognitive therapy was less effective than IPT or Imipramine in severely depressed patients. However, recent findings suggest that CBT might be as effective as medication in treating moderate to severe depressive disorders, especially in the initial phases of depressive disorders<sup>146</sup> and it might be better than IPT in treating severe depressive disorders<sup>144</sup>. Cognitive therapy may have a role in preventing relapse of depressive disorders. Several follow up studies have indicated that patients receiving acute treatment with cognitive therapy had lower relapse rates and sought less treatment subsequently than patients who were treated with tricyclic antidepressants<sup>27</sup>.

According to the NICE guidelines in the UK, patients with mild to moderate depressive disorders should be advised exercise, CBT based self-help, computerized cognitive behavioural therapy (CCBT), problem-solving therapy, brief CBT, or counselling<sup>147</sup>. For the initial treatment of mild depressive disorders, antidepressant medications are not recommended as

the risk-benefit ratio is poor. For those presenting with moderate to severe depressive disorders, Problem-solving therapy (PST), counselling, Couple-focused therapy, Psychodynamic psychotherapy (for the treatment of the complex co-morbidities that may be present along with depressive disorders), CBT or IPT should be considered along with the medication. NICE Guidelines clearly state that CBT is the psychological treatment of choice for moderate or severe depressive disorders. A number of RCTS have suggested that, by the end of treatment, CBT is as effective as antidepressants in reducing depressive symptoms<sup>21</sup>.

## **1.9 Summary**

In summary, CMDs are common throughout the world, have significant personal, social and financial cost, which poses certain challenges in terms of diagnosis and therefore management across different cultures. We still don't know much about its aetiology, but available information suggests an interaction between biological and psycho-social factors within a cultural context. The management of CMDs involve use of both biological and psycho-social approaches. Although the choice of treatment should take into consideration the individual needs of the patient as well as evidence. The evidence so far suggests that antidepressant medication, ECT, IPT and CBT all are effective. Overall, CBT is as effective as medicines, but better than medicines in prevention of relapse.

## **CHAPTER 2: COGNITIVE BEHAVIOUR THERAPY (CBT) FOR COMMON MENTAL DISORDERS (CMDs)**

Since its early days during the 1960's, Cognitive Therapy has become one of the main forms of psychological treatment. Although initially limited to the treatment of depressive illness, it has proved to be effective for anxiety disorders, phobia, obsessive compulsive disorder, somatic problems, eating disorders, sexual dysfunction, borderline personality disorders & schizophrenia<sup>63, 148-153</sup>. Cognitive Therapy has been evaluated in different settings including primary, secondary and tertiary care<sup>154</sup>. It has also been used effectively in different age groups with success<sup>155</sup>.

There is sufficient evidence to suggest that CBT is an effective treatment for CMDs and it is now included in National Treatment Guidelines<sup>11, 156- 159</sup>. It can be provided in both individual and group settings<sup>160</sup>. Cognitive therapy has been provided in less intensive forms after a shorter duration of training, using a manual and under supervision<sup>161</sup>. CBT has been shown to be effective for prophylaxis<sup>162</sup> and for the prevention of depressive relapse<sup>24</sup>. CBT has also been used in the form of self-help<sup>163</sup>.

### **2.1 Background**

Philosophically, cognitive therapy can be traced back to stoic philosophers

particularly, Zeno of Citium, Chrysippus, Cicero, Seneca, Epictetus and Marcus Aurelius. Epictetus famously wrote in “The Enchiridion”, “Men are disturbed not by things but by the view which they take of them”. Similar to stoic philosophers, eastern philosophies such as Taoism and Buddhism have emphasized that human emotions are based on ideas<sup>164</sup>.

During the middle of the last century personal construct therapy was developed to alter the patient’s ongoing conscious daily experiences<sup>165</sup>. During the same time period other therapists added different methods and conceptualizations to therapies designed to alter the ongoing conscious experience or cognitions of the patients<sup>166, 167</sup>. Rational Emotive Behaviour Therapy (REBT) was developed in this background<sup>168, 169</sup>. Ellis linked the environmental or Activating events (A) to the emotional Consequences (C) by the intervening Beliefs (B). Thus this therapy aims at making the patient aware of his irrational beliefs and the inappropriate emotional consequences of these beliefs. REBT is designed to modify these underlying irrational beliefs. CBT originated with the formulation of a cognitive model of depressive disorder, which evolved from systematic clinical observations and experimental testing<sup>170, 171</sup>.

## **2.2 Principles and Practice**

Cognitive therapy is an active, directive, time-limited, structured approach

used to treat a variety of psychiatric disorders. It is based on the principle that an individual's affect and behaviour are largely determined by the way in which he perceives the world (his cognitions). These cognitions are based on attitudes or assumptions, developed from previous experiences. Therapeutic techniques are used to identify, reality test and correct distorted conceptualizations and the dysfunctional beliefs underlying these cognitions. The therapist helps the patient to think and act more realistically and adaptively about his psychological problems and thus reduce symptoms. Thus the therapy is aimed towards testing specific misconceptions and assumptions through (1) monitoring negative automatic thoughts, (2) recognizing the connection between cognition, affect and behaviour, (3) examining the evidence for and against automatic negative thoughts, (4) substituting more reality-oriented interpretations for these biased cognitions and learning to identify and alter dysfunctional beliefs which predispose him to distort his experience <sup>5, 164</sup>. Therapy starts with giving the patient rationale for cognitive therapy. Next he is trained to recognize, monitor and record his thoughts. The cognitions and underlying assumptions are discussed and examined for logic, validity and adaptiveness. The patient learns to question his own thinking patterns. Behavioural techniques are used with more severely depressed patients to change behaviour as well as to elicit cognitions associated with specific behaviours. CBT also assumes that our thoughts, emotions, behaviours, bodily symptoms and events are

linked and that by making changes in our thoughts and some of the behaviours we can change the way we feel and act in certain situations. Commonly used techniques include, cognitive restructuring, downward arrow technique, Socratic dialogue and behavioural experiments. However, therapists also teach patients how to solve problems, improve relationships, manage conflicts and improve communication and social skills<sup>21</sup>.

The patient usually meets with a therapist for between 8 to 20 sessions. The sessions are usually arranged weekly. Each session will last for nearly an hour. The first and sometimes the second session involve a detailed assessment. In the next few sessions the therapist will help the patients in formulating and finding solutions to their problems, and changing the way they think or communicate with others especially with the family members. The therapy has certain routines. At the end of each session the therapist will give the patient some material to read or listen to on tapes. They will also ask them to do some exercises. Each new session will start with feedback from the previous session and then the therapist will agree with the patient on what needs to be done or discussed in the current session. The therapist will take feedback from the patient during each session; clarify if there is something that needs further explaining<sup>21</sup>.

### **2.3 How CBT is different from other therapies?**

There are two important aspects to how Cognitive therapy differs from conventional psychotherapy: firstly, in the formal structure of the interviews and secondly, in the types of problems that are focused upon. Since a “collaborative empiricism” approach is used by Cognitive Therapists with their patients, the therapist is continuously active and deliberately interacting with the patient. The therapist structures the therapy according to a particular design which engages the patient’s participation and alliance, using his resourcefulness to stimulate the patient to become actively engaged in the various therapeutic operations. In contrast to psychoanalysis, “here and now” problems are central to the CBT approach. Little attention is paid to childhood recollection except to clarify present observations. The patient’s thinking and feeling during the session and between the sessions are central to the therapy. The cognitive therapist actively collaborates with the patient in exploring his psychological experiences, setting up schedules of activities and making homework assignments. Cognitive therapy contrasts with behavioural therapy in its greater emphasis on the patient’s internal experiences such as thoughts, feelings, wishes and day dreams and attitudes. The overall strategy of cognitive therapy may be differentiated from the other schools of therapy by its emphasis on the “empirical investigation” of the patient’s automatic thoughts, inferences, conclusions and assumptions<sup>21</sup>.



## **2.4 The Cognitive Model**

The cognitive model of depressive disorder evolved from the experimental method in science. The interplay of a clinical and experimental approach has allowed progressive development of the model and of the psychotherapy derived from it. The cognitive model postulates three specific concepts to explain the psychological basis of depressive disorder; (a) the cognitive triad, (b) cognitive errors and (c) the schemas (Dysfunctional attitude)<sup>164</sup>.

### **2.4.1 The Cognitive Triad**

It is based on three major cognitive patterns that induce the patient to regard himself, his future and his experiences in an idiosyncratic manner. The first component of the triad revolves around the patient's negative view of himself considering himself to be undesirable and worthless. The second component consists of the tendency of interpreting ongoing experiences in a negative way, representing defeat or deprivation, by the depressed person. The third component consists of a negative view of the future with anticipation of continuation of difficulties or suffering, for indefinite times.

### **2.4.2 Cognitive Errors**

When an individual erroneously mentally processes information, this results in cognitive errors. Despite the presence of contradictory evidence, these

thinking errors maintain the depressed person's belief in the validity of the negative concepts<sup>164</sup>.

- "Arbitrary inference (Jumping to conclusions) refers to the process of drawing a specific conclusion in the absence of evidence to support the conclusion or when the evidence is contrary to the conclusion.
- Selective abstraction consists of focusing on a detail taken out of context, ignoring other more salient features of the situation and conceptualizing the whole experience on the basis of this fragment.
- Overgeneralization refers to the pattern of drawing a general rule or conclusion on the basis of one or more isolated incidents and applying the concept across the board to related and unrelated situations.
- Magnification and minimization are reflected in errors in evaluating the significance or magnitude of an event that are so gross as to constitute a distortion.
- Personalization refers to the patient's tendency to relate external events to himself when there is no basis for making such connection.
- Absolutistic, dichotomous (black and white) thinking is manifested in the tendency to place all experiences in one of two opposite categories; for example, flawless or defective, immaculate or filthy,

saint or sinner. In describing himself, the patient selects the extreme negative categorization”<sup>21, 164</sup>.

### **2.4.3 Dysfunctional Attitudes**

Although depressed patients may have positive features in their life, these do not provide them with the resilience to overcome their pain inducing and self-defeating attitudes, these self-defeating beliefs are referred to as ‘dysfunctional attitudes’. Dysfunctional attitudes reflect the content of stable cognitive schemas<sup>172</sup>. It is deduced that when a person faces a particular life circumstance, a schema related to the circumstance is activated. Data is moulded into cognitions based on these schemata. Accordingly, a schema establishes the basis for the screening out, differentiating and coding the stimuli that confront the individual. A person categorizes and evaluates his or her experiences through a matrix of schemas. Thus the kind of schemas employed determines how an individual will structure different experiences. A schema may be inactive for long period of time but can be energized by the specific environmental inputs. The schema activated in a specific situation directly determines how the person responds<sup>21</sup>.

## **2.5 Summary**

In summary, CBT evolved over many years and has its philosophical basis

in stoic philosophy. It focuses on the patient's cognitive errors and underlying beliefs and tries to change these through looking at the evidence which contradicts these cognitions through collaborative empiricism. However, psychotherapies were developed in the Western world and therefore we need to look into the interaction between psychotherapies, in particular CBT, and different cultures.

## **CHAPTER 3: CULTURE AND COGNITIVE BEHAVIOUR**

### **THERAPY (CBT)**

Many authors have highlighted that the process of counseling and psychotherapy is influenced by cultural differences<sup>173-181</sup>. In recent times, many therapists have attempted to address the issues surrounding cultural sensitivity<sup>182-185</sup>. It has been proposed that “because most counseling theories were developed by white males from America or Europe, it is possible that they may conflict with the cultural values and beliefs of third world or minority individuals”<sup>186, 187</sup>. Correspondingly, it has been proposed that CBT is as value laden as any other psychotherapy<sup>188</sup>.

#### **3.1 Culture**

There is still uncertainty about how the term ‘Culture’ should be understood and the associated phenomena to which it refers<sup>189, 190</sup>. Consequently, for example, in everyday use the terms ‘culture’, ‘ethnic group’ and ‘race’ are regularly used as if they were wholly interchangeable. There are many different ways of describing the term culture. For example, Triandis prefers a broad-brush approach, with the result that he includes the physical as well as the subjective aspects of the world in which we live in his definition of culture<sup>191</sup>. On this basis, he argues that environmental features such as roads, buildings and so forth can be seen as constituting the ‘physical’

elements of culture, as opposed to myths, values and attitudes and so forth which he identifies as its more 'subjective' elements. Similarly, Fernando suggests that "in a broad sense, the term culture is applied to all features of an individual's environment, but generally refers to its non-material aspects that the person holds common with other individuals forming a social group"<sup>92, 193</sup> In contrast to this all-inclusive approach, Reber defines culture much more specifically, as "the system of information that codes the manner in which people in an organized group, society or nation interact with their social and physical environment"<sup>194-196</sup>. In arguing that cultures are systems and structures that people must learn, he identifies culture quite specifically as a *cognitive* phenomenon. However, we need to keep in mind the physical manifestations of this phenomenon.

Anthropologists propose that there are three components of 'culture': things or artefacts, ideas and knowledge and patterns of behaviour. They also suggest that the most fundamental concept of culture is the use of symbols. The term "culture" traces its roots back to German Romanticism and the idea of the *Volksgeist* (the "spirit" of a people), which was adapted for anthropological use. The term diffused into British anthropology and later into American anthropology. The term "culture" denotes the *totality* of the humanly created world, from material culture and cultivated landscapes, via social institutions (political, religious, economic etc.), to knowledge and

meaning. Culture has been defined as "the set of distinctive spiritual, material, intellectual and emotional features of society or a social group, and that it encompasses, in addition to art and literature, lifestyles, ways of living together, value systems, traditions and beliefs"<sup>197</sup>.

### **3.2 Culture and psychological interventions for Common Mental Disorder (CMDs)**

Most of the literature in this domain has been published in the west which instead of comparing psychotherapy techniques, focused on cultural differences and mostly gives personal opinions and observations of the authors.

It has been suggested that there are four core value dimensions that distinguish Western from the Asian culture<sup>176, 198</sup>. Although not completely dichotomous, these can be considered as; "individualism-communalism, cognitivism-emotionalism, free will-determinism and materialism-spiritualism". Asians (mostly South Asians) are usually community oriented and are predisposed to spiritual explanations. They have an emotional approach towards problem solving which not only affects how they cope with their routine emotional difficulties but also affects the long term development and maintenance of problems. The notion of the 'script of life' being already written has enormous implications<sup>176</sup>. The Islamic view is that

some aspects of life, like life and death are predetermined (taqdeer); others are under a person's control<sup>199</sup>. However, in the Islamic faith there is special emphasis on seeking treatment for an illness. This belief definitely controls the way people think. The Hindus believe in a similar "karma". Buddhism takes a non-linear view of life<sup>198</sup>. The principles of mindfulness (defined as "a kind of non-elaborative, nonjudgmental, present-centered awareness in which each thought, feeling, or sensation that arises in the attentional field is acknowledged and accepted as it is") derived from Buddhism, are being researched in the West<sup>200-202</sup>.

It has been suggested that as compared to Western societies that are work and activity centered, Asian societies are relationship centered<sup>203</sup>. This has important implications in delivering therapy, in that the therapy should perhaps be inclusive of family members. Consideration needs to be given that people in such cultures might be behaving, thinking and feeling in communion with the family rather than as individuals and there is great importance of social hierarchies based on caste, sect, race, language or even colour<sup>38, 176</sup>.

Shame and guilt are important day-to-day emotions in Asian cultures and shaming is seen as the most effective method of social control<sup>204, 205</sup>. Similarly, anger is another emotion that needs consideration in Asian



cultures. Also, issues concerning sin and guilt are associated with cultures that have a strong religious component<sup>198</sup>.

Attitudes people hold towards health and the health system also affect their health seeking behaviours. Asian patients tend to look for ‘cures’ so it is common for them to consult more than one doctor for a problem<sup>176, 198, 206, 207</sup>.

Whether this applies to psychotherapists too is difficult to say. However, if the Asian model of health seeking follows the Asian model of spiritual leadership, the concept of the guru or peer, who is followed throughout one’s life time, it is possible that patients might go to their therapists for reasons of faith rather than reason<sup>198</sup>. Common strategies to treat and reduce mental health problems include religious activities, marriage etc., and the therapist needs to be aware of these. It will be interesting to point out however, that when it comes to faith healers people usually follow them for the rest of their lives. It has been suggested that the Western concepts of psychotherapy for example taking responsibility for one’s own life experiences might cause conflict in Asian patients<sup>198, 208, 209</sup>. However, most of such theories come from observations of the writers rather than being based on a scientific study of the culture<sup>210</sup>.

### **3.3 CBT & Culture**

Evidence has suggested that CBT is as value laden as any other psychotherapy<sup>188, 211</sup>. People with CMDs usually have beliefs towards self, others and the world, that are unhelpful. Such core beliefs, underlying assumptions and even the content of automatic thoughts might vary with culture<sup>212, 213</sup>. An important aspect of Cognitive Therapy is that it is tailored to the individual's needs. A collaborative negotiated approach can help therapists understand and adapt to the culture of the client, providing they know how to read cultural cues.

Although some suggest that Asian clients might use an emotional approach in solving their problems others say that they like focusing on thoughts rather than emotions<sup>188, 214</sup>. Sue et al have proposed that Asian clients appreciate addressing the presenting problem directly, and some initial progress, evident even in the first session<sup>175, 213</sup>.

Most research on CBT originates from the UK and the USA and now researchers have focused on applying CBT techniques to members of ethnic minority groups in these countries. However, this is an emerging area and only a limited amount of research work has been carried out in this area so far<sup>188, 215, 216</sup>. Various cognitive therapists have described their experience of working with American Indians, Alaska native people, Latinos and Latinas,

African Americans, Asian Americans, people of Arab heritage and Orthodox Jews<sup>188, 217</sup>. There is now literature available from Western countries describing experience of cognitive therapists working with ethnic minorities (Asians living in the West) and the efficacy of CBT has been proved<sup>213, 218, 219</sup>.

It should be pointed out here that in the real world a pure CBT model is hardly used by expert therapists. Psychotherapists from both psychology and psychiatry backgrounds use an eclectic approach.

The newer ideas in CBT such as third wave therapies are exciting developments and highlight the evolving nature of CBT. The examples of third wave therapies include mindfulness and acceptance and commitment therapies. These therapies have their origin in eastern religious tradition (mindfulness for example was derived from Buddhism). Therefore, it might be relevant to briefly describe here mindfulness and the Islamic tradition of mindfulness (Sufism)<sup>21</sup>.

### **3.4 Mindfulness & the Islamic Context (Sufism)**

For thousands of years, Mindfulness based techniques have been applied in human endeavours. They have been found of great value by Hindus, Buddhists, Muslims and Christians; in India, Asia, Europe and America;

historically, in the Middle Ages and in modern times<sup>220</sup>. Like Christianity and Judaism, Islam developed its mindfulness tradition well after its foundation. It was not until the 9th century AD, however, that the mystical tradition of “tasawwuf” (Sufism) was developed<sup>221</sup>. The heart of Sufism is a search for a direct confrontation with the Divine, often visualized as Love or as an all-consuming fire<sup>222-224</sup>. Sufis used poetry and spoke in stories and used symbols. Probably the most renowned Sufi in the Western world is Rumi. One popular means of communication of Sufi ideas is qawali, particularly in South East Asia. The devotional practices of Sufis vary widely. Commonly used practices involve, Zikar (remembrance of god); muraqba (meditation); breathing and exercises of focusing; and visiting tombs of saints and righteous people.

In South Asia, four major Sufi orders persist, namely, “the Chishti Order, the Qadiriyyah, the Naqshbandiyya, and the Suhrawardiyya”. Of them the Chishti order is the most visible. Khwaja Moinuddin Chishti who came from Afghanistan in 1192 AD and started living permanently in Ajmer in 1195, introduced it in Indo Pak. This shows the linkage of mindfulness in this region

### **3.5 Summary**

In summary, cultural factors should be taken into consideration while giving

psychotherapy especially CBT in non-Western cultures. However, culture is a complex phenomenon and a “dynamic process” rather than a static entity or event. It is noted that people have been practicing Islamic mindfulness (Sufism) in the region under study, but this is a vast field and might require a detailed study and practice.

## **CHAPTER 4: HEALTH SYSTEM IN THE PASHTO SPEAKING REGION OF PAKISTAN AND AFGHANISTAN**

### **4.1 The Pashto speaking “region” of Pakistan and Afghanistan**

Pashto is an Eastern Iranian language belonging to the Indo-European family and is spoken in south and southeastern part of Afghanistan, Khyber Pakhtunkhwa, Federally Administered Tribal Areas (FATA) and northern Baluchistan in Pakistan, in the northeastern Iran in South Khorasan Province to the east of Qaen, near the Afghan border, and in Tajikistan. In addition, sizable Pashto-speaking communities are also present in the Middle East (United Arab Emirates, and Saudi Arabia), United States, United Kingdom, Thailand, Canada, Germany, Netherlands, Sweden, Qatar, Australia, Japan, Russia, New Zealand, etc<sup>225</sup>.

Pashto uses an Arabic Script and is reported to be first written in the 16<sup>th</sup> century. It is second in importance among the Iranic languages and is one of the official languages of Afghanistan<sup>226, 227</sup>.

Since we are focusing on Pashto speaking population of Khyber Pakhtunkhwa and FATA in Pakistan; and South Eastern Part of Afghanistan to the extent of Kabul, we will refer to it as the “region” in the description ahead.

In this region, exact number of Pashto speaking people is not known but most estimates range from 45 to 55 million. In Afghanistan, it is the first language of 11 to 15.4 million (40 and 55%) Afghanis, and 2.8 to 7.8 million (10 to 28%) speak it as a second language. Pashto has more than 25 million speakers in Pakistan (15.42 % of the population)<sup>228, 229</sup>.

Through ages, this region has been home to various civilizations, including the ancient Iranian peoples who established the dominant role of Indo-Iranian languages in the region. The region has been an important part of large regional empires. Also, this region has faced multiple traumas and difficulties including severe floods, earthquakes, Pak-Afghan-Russian war (1979-1989), burden of Afghan refugees in Pakistan, civil war in Afghanistan; and terrorist attacks and bombing in the aftermath of 9/11. This brought destruction to the region and affected the lives of ordinary people, who in addition to feeling terrified, faced further sanctions by the west<sup>230</sup>.

Since there is not enough reliable data for this specific region, overall data from both countries have been shared, in this chapter, considering it to be representative of the Pashto speaking region of the corresponding country, as well.

## **4.2 Health system of the region**

According to the 2014 WHO statistics, Pakistan only spends 2.6% total expenditure on health as % of GDP<sup>231</sup>. This is far less than the figures from developed countries and less than all the countries of the region (the comparative figures according to WHO for up to 2014 were, USA 17.1%, Canada 10.4%, UK 9.1%, France 11.5%, Germany 11.3%, China 5.5%, India 4.7%, Sri Lanka 3.5%, Bangladesh 2.8%, Nepal 5.8%, Bhutan 3.6%, Maldives 13.7%). Even it is 8.2% for Afghanistan. Public and private health care facilities are available in Pakistan. In the private sector, there are some accredited outlets and hospitals, but also many non-registered hospitals, Medical General Practitioners and traditional healers are practicing<sup>232</sup>. Some public-private partnership initiatives in the urban areas exist through franchising of private health outlets. These have been successful in promoting positive health behaviour among the people. However, in health practices in rural areas, primary health care activities have not brought about the expected improvements and more than 90 per cent of infant deliveries are performed by untrained or semi-trained dais or Traditional Birth Attendants (TBAs) in some areas of rural Pakistan<sup>233</sup>. There are many reasons to it but a poorly functioning referral system may be partly to blame<sup>21</sup>.



In Pakistan, including Khyber Pakhtunkhwa, at community level, Lady Health workers (LHW) play an important role in running the network of basic health facilities at basic health units (BHU) (each serving 10-20 thousand population) and rural health centers (RHC) (each serving 25-50 thousand population). The next referral levels are the tehsil hospital (serving 0.5–1 million population) and the tertiary level hospital (serving 1–2 million people). However, basic level facilities have restricted hours of operation, are often located at a considerable distance from the population and have a shortage of manpower<sup>233</sup>. In this region, cultural beliefs and perceptions, socio-demographic status, women's autonomy, low literacy level of the mothers and large family size, economic conditions, physical and financial accessibility of the health services and disease pattern and health service issues, all affect health seeking behaviours of the population<sup>234</sup>.

Afghanistan's health system is considered to be one of the poorest due to years of conflict and political instability, a collapsed economy, and recent years of severe drought<sup>235</sup>. Such conditions intensify an existing poor health situation. There is a serious shortage of health care workers at every level. Healthcare facilities are in urgent need of reinstatement. Over time in Afghanistan, every family is effected through physical injury and mental distress due to the impact of conflict and remaining deadly land mines and unexploded ordnance.

Afghanistan has an ethnically, religiously and linguistically diverse population. This has been so since the inception of the state in 1747 AD<sup>236</sup>. Afghanistan has experienced a gradual urbanization since the late 1990s but the country remains one of the world's least urban societies. In 1999 around 79% of the country's population lived in rural areas, compared to around 74% in 2013-14<sup>237</sup>. The Afghan population is estimated to increase to 82 million by 2050<sup>238</sup>. It is important to note that roughly 2.7 million Afghan refugees have been living in Pakistan and Iran but now due to the geopolitical situation, the process of returning back has been started.

Afghanistan ranks 15<sup>th</sup> least developed country in the world according to the Human Development Index due to lack of foreign investments, corruption and the insurgencies. The average life expectancy is estimated to be around 60 years for both sexes. Life expectancy at birth for male and females is 59/61 years, respectively<sup>239</sup>. As of 2013, 46% of Afghanistan's population are under 15 years of age and 74% of the population live in rural areas. The average woman gave birth to five children during her life and 6.8% of all babies died in child-birth or infancy<sup>237</sup>. The country has 2nd highest maternal mortality rate in the world (1700/ 100000). Less than 15% of deliveries are attended by trained health workers, mostly traditional birth attendants. It has the highest infant mortality rate in the world, estimated in

2015 to be 115.08 deaths/1,000 live births<sup>240</sup>. Under five-year mortality is 257 per 1000 live births, so 25% of children die before their fifth birthday. Lack of basic health care and malnutrition contribute to the high death rates. Less than 40% of Afghan children receive Immunization Coverage in the form of life-saving vaccinations. Afghanistan has one of the highest incidences of people with disabilities, with around a million people affected. About 0.08 million people have missing limbs; most of these were injured by landmines.

A number of hospitals and clinics have been built over the last decade, with the most advanced treatments being available in Kabul.

#### **4.3 Mental Health in the region**

Mental health is a major health concern. It becomes even more important in communities where there is insecurity, terrorism and unpredictability. Experts estimate that approximately 30–50% of a population undergoing violent conflict develop some level of mental distress. Not to forget, residual mental health problems that appear normally in any population<sup>235</sup>.

An estimated 10-16% of the general population in Pakistan suffers from mild to moderate psychiatric illnesses. In Khyber Pakhtunkhwa, the prevalence of Depression, a common mental disorder (CMD), is reported to

be 5 % in Urban and 3% in rural areas. Two percent urban and 2.5 % rural population suffers from severe mental illnesses. Nearly 16 per 1000 of the children between three to nine years of age suffer from severe mental retardation. The prevalence of epilepsy was found to be 9–16 per 1,000. There are no data for other neuropsychiatric conditions<sup>241, 242</sup>.

The last decade has witnessed the opening of numerous medical colleges in Khyber Pakhtunkhwa, both in public and private sector, however, the standard of care varies among different sector medical colleges. Most of these colleges have psychiatry departments providing services. Basic health units providing primary care to rural populations, do not have mental health professionals and patients with psychiatric problems have to go to the outpatient departments of district and teaching hospitals. According to Mental Health Atlas 2005, the number of total psychiatric beds per 10000 people was 0.24 while there were 0.2 psychiatrists and psychologists, 0.08 psychiatric nurses and 0.4 social workers per 100000 people in Pakistan. Pakistan spends only 0.4% of the total health budget on mental health<sup>243, 244</sup>. It has been estimated that there are nearly 1.5 inpatient beds per 100 000 populations in Pakistan. As per the membership of Pakistan Psychiatric society, there are around 400 Psychiatrists in the country (around 50 in Khyber Pakhtunkhwa). Majority of these psychiatrists are based in major urban centers in Pakistan<sup>245</sup>. Psychology is also an underdeveloped

discipline. Although universities are conducting MSc programmes in Psychology, there are only limited facilities for further education and even rarer job opportunities. Most departments of psychiatry don't have a psychology department attached to these. The state of nursing is even worse. There were only 52 trained psychiatric nurses in 2001 and 125 as per WHO Atlas of 2005. There is no programme for mental health social workers<sup>246</sup>.

The mental health situation in Afghanistan is characterized by a highly felt need and an extremely incapacitated mental health care system. The social and family structures have been destroyed due to external and internal migration of millions of Afghans. Prevalence figures of mental disorder among Afghans are hardly available but the available sources indicate that CMDs (depression and anxiety disorders) are extremely prevalent, mainly among women and children. It is generally understood that posttraumatic stress disorder is common, but exact figures are not available. Data on severe neuro-psychiatric conditions such as schizophrenia and epilepsy is also not available. Substance related disorders, in particular dependence to opium, are common in the poppy growing areas in the south and east of the country<sup>247, 248</sup>.

Much of the infrastructure has been demolished and most qualified

manpower and technical expertise have left the country. According to published statistics the country has eight psychiatrists, 18 psychiatric nurses and 20 psychologists in the entire country<sup>249</sup>. The governmental health care system is in very poor condition. In Nangarhar, the department of neuropsychiatry (the only psychiatric facility in East Afghanistan) has only a few beds, virtually no psychotropic drugs, and lacks specialist human resource, with only one certified psychiatrist, and no psychiatric nurse. Two other cities in Afghanistan, Kabul and the northern town of Shebargan, have treatment facilities for mental health problems. The Ministry for Public Health manages the Kabul Psychiatric Hospital, which has inpatient services and a drug treatment center called the Jangalak Substance Misuse Centre. In 2009, this center saw more than 800 in-patients suffering from drug addiction, mainly heroin and opium addiction<sup>250</sup>. The vast majority of Afghans are deprived of any mental health care facilities at all. Only one organization is running a programs aimed at local capacity building and it provides training materials in Pashto for doctors, nurses/midwives and community volunteers and in clinics, where there are trained personnel and essential mental health drugs are supplied<sup>251</sup>.

Since it was felt that integration of mental health into the basic health care services of Afghanistan, could substantially increase the effectiveness of mental health services, the Afghanistan mental health strategy 2010 was

devised envisioning that all people in Afghanistan have access to a community-based, comprehensive and coordinated system of mental healthcare. It commits to promoting a system of recovery and mental wellbeing which is also promoted outside the health sector as an issue that requires multi-sectoral commitment and effort at the community level.

In short, there are strong reasons to presume a huge morbidity of mental disorders in this region and there is an urgent need to establish effective and culturally appropriate mental health services.

#### **4.4 Traditional healing practices in the region**

Traditional healers are important component of the mental health system in the region as this is cultural based approach to health and illness. Spiritual leaders (Pirs), Alims (Religious scholars), homeopathic doctors, naturopathy (Tib), Herbalists, acupuncture, Hakims (practitioners of Greek/Indian medicine), Jerrahs (treatment through opening veins, practicing old Greek, Arab or Indian healing practices), Sufism based healers, Amils (magicians), palmists and other fortune tellers, Bonesetters and Quacks, all offer help for physical, sexual, psychological and relationship problems<sup>246, 252</sup>. It has been suggested that the use of the services of spiritual healers might be greater in Islamic society<sup>253</sup>. Faith healers in the region (also including India and Bangladesh) have been reported to be the major source of care for people

with mental health problems, particularly women with little education<sup>252, 254, 255</sup>. The main reasons for consulting these healers are: proximity, affordable fee, availability, family pressure and the strong opinion of the community<sup>234</sup>. A study found that patients with different psychiatric disorders sought multiple traditional healing methods for their problems, including; somatoform (73%), personality/conduct disorder (73%), schizophrenia (70%), affective disorder (68%) and anxiety disorders (55%). More male than female patients used multiple traditional healing practices<sup>252</sup>. Individuals with severe psychotic illnesses are taken to shrines or *Ziarats*, and are chained there for months or even years, at the mercy of the caretakers of the shrine, who often receive financial gains from the families of these patients. Hygiene issues, starvation, and physical illnesses and infections frequently result in a distressing and early death for these patients. Even people with CMDs seek refuge to traditional shrines<sup>21</sup>.

A survey of patients attending the family physician department at a teaching hospital reported that 45 (11.6%) of the respondents were also attending spiritual healers. The study highlighted the role of the religion and spirituality in healing in Pakistani society as well as the expectations people have from the healers<sup>256</sup>.



#### **4.5 Summary**

In summary, it is noted that there are serious inadequacies in the health system prevailing in the Pashto seeking region of Pakistan and Afghanistan. This includes the negative growth of mental health in the region as well. There are a lot of influence of traditional healers in this region, however, awareness is rising related to mental health issues and their pharmacological and psychological remedies.

## **CHAPTER 5: COMMON MENTAL DISORDERS (CMDs) IN THE PASHTO SPEAKING REGION OF PAKISTAN AND AFGHANISTAN**

There is a high incidence and prevalence of CMDs including posttraumatic stress disorder in this region, although reliable figures are not available, especially in Afghans (particularly refugees) due to witnessing the loss of family and homes in Afghanistan.

### **5.1 Studies of prevalence of CMDs in the region**

Mumford and colleagues studied prevalence of CMD in Chitral, and reported that 46% of women and 15% of men suffered from anxiety and depressive illness<sup>257</sup>. They estimated that literate subjects had lower levels of emotional distress than the illiterate. Higher socio-economic status was associated with less emotional distress. Members of joint and nuclear families were similar. A survey to estimate the CMD in women from the Northern (Gilgit) areas found that 50% of the women had anxiety and/or depressive illness; 25% suffered only from anxiety, 8% from depressive illness and 17% had features of both<sup>258</sup>. A hospital based study reported 30% prevalence of Postnatal depression in Peshawar<sup>259</sup>. Khurshid et al while studying the impact of terrorism on the people of Khyber Pakhtunkhwa, assessed the frequency of depression and post-traumatic

stress disorder in almost all the major Pashto speaking cities of Khyber Pakhtunkhwa and FATA. They found out that the frequency of depression was 22.22% and that of PTSD was 23.55%. A systematic review of the literature from Pakistan showed mean overall prevalence of CMDs in the community population to be 34% (overall mean prevalence of CMDs was 45.5% for women, (varying from 29-66%) and 21.7% for men, varying from 10-33%)<sup>260</sup>. The factors positively associated with CMDs were found to be, female sex, middle age, low level of education, financial difficulty, being a housewife, and relationship problems. Those who had close confiding relationships were less likely to have CMD. There were no rigorously controlled trials of treatments for these disorders published until then. The reviewers concluded that the available evidence suggests a major social cause for CMDs. However, evidence is limited because of numerous methodological problems.

There is no disagreement about the very high burden of mental health disorders in Afghanistan, much of which can be attributed to deep social trauma, armed conflict coupled with natural disasters, double-digit unemployment, acute poverty, dissolution of social capital, and inadequate access or lack of access to mental health services<sup>261</sup>. Even Pakistani clinicians have reported high rates of anxiety and depressive symptomatology in Afghani population in refugee camps in Pakistan<sup>262</sup>. A

review of studies revealed high rates of CMDs amongst Afghani women in Kabul with 42% having symptoms diagnostic of posttraumatic stress disorder and 97% and 86% had depression and anxiety, respectively<sup>263</sup>. A nationwide survey conducted in 2002 found high levels of depression symptoms (59.1 % in males and 73.4% in females), anxiety symptoms (59.3% in males and 83.5% in females) and PTSD (32.1% in males and 48.3% in females)<sup>264</sup>. An in-depth survey conducted in 2003 in Nangarhar Province found high figures of depression and anxiety in women as compared to men, with 58.4%, 78.2% and 31.9% having symptoms of depression, anxiety and PTSD<sup>265</sup>. The study found a clear relation between the number of traumatic events and the likelihood of developing psychopathology. A recent study among widows in Kabul reported depression among 78.6%<sup>11</sup>. These studies show that in times of war and conflict, mental health is influenced by a combination of demographic and socioeconomic characteristics linked to social exclusion mechanisms that were in place before the conflict began<sup>266</sup>.

## **5.2 Risk factors associated with CMDs in the region**

On a preliminary level researchers have tried to look into risk factors associated with CMDs in the region. Husain et al conducted a house to house survey in the North West Frontier Post (now Khyber Pakhtunkhwa) and found that Sixty percent (95/158) of women and forty-five percent

(140/313) of men scored 9 or more on the SRQ. Higher rates of depressive symptoms were associated with higher social problem scores, less social support and greater disability. They summarized that people of this region report more depressive symptoms than other communities in Pakistan. This also reflects the very high degree of social stress experienced in the region, which has been affected by years of turmoil in neighbouring Afghanistan<sup>267</sup>. A survey conducted in a general hospital in Pakistan found that 47.2% of psychiatric patients had a social problem and problems with primary support group occurred in 33.4%, while 14.2% had relational problems and 7.8% had problems relating to bereavement or death. Social problems were more common in women (mostly with their in-laws) and patients who had adjustment or depressive disorder<sup>268</sup>. A case control study to investigate vulnerability factors among depressed patients found that lack of an intimate, confiding relationship, was statistically significantly associated with depressive illness<sup>269</sup>.

Prejudice based on strong cultural beliefs, discrimination, and social disparities exist between different groups in Afghan (and tribal Pashtun society in Pakistan) society. The “unwritten rules of Pashto culture-the Pashtunwali (a code of honour)” and particularly the central role given to the tribe (community) and religion, provide the source of norms for all ethnic groups<sup>270, 271</sup>. The non-adherence to these codes, due to any reason,

may predispose an individual to experience social exclusion which predispose them to have CMD. A study from Afghanistan reported that exposure to war has resulted in risk of mental disorders across different social groups<sup>266</sup>. The functioning of Afghans, however, is not affected on a daily basis because of their resilience<sup>272, 273</sup>. However, persons with disabilities, widowed, divorced or separated women, the poor, the unemployed and uneducated as well as the elderly, and those from minority ethnic groups, are all at higher risk of developing CMD. According to the literature, perception of low social status is associated with depression and other mental health outcomes<sup>274</sup>. Identifying the links between social status and the response to trauma can improve relevant mental health policies and services<sup>275-277</sup>.

### **5.3 Presentation of CMDs in the region**

Patients with CMDs often present with somatic complaints in this region. All the studies on the subject unanimously agree to this fact. In one of the first studies published from Pakistan on this topic, it was shown that the Dhat syndrome (undue worry about the weakening effects of the passage of semen) was reported by 30% of men, and to an equal extent by patients with “functional” and “organic” diagnoses<sup>257</sup>. It was associated with a diagnosis of depressive illness. They have argued that this complaint should be primarily regarded not as the focus of a culture-bound syndrome, but as a

culturally determined symptom associated with depressive illness

#### **5.4 Economic Burden of CMDs in the region**

Three major factors contribute towards the economic burden of depression, i.e., high prevalence of the disease; disability of the patient due to the disease; and chronic lifelong characteristic and nature of the illness. It has been reported that 85% of the patients attending a psychiatric facility in Pakistan were spending over Rs. 3133 (51.40 US dollars) per month as general expenses on health<sup>245</sup>. In a hospital based study, the overall cost of patients with depressive disorder was found to be Rs. 472542 with Rs. 73026 (15%) in direct and Rs. 399516 (85%) in indirect costs with a ratio of 1:5.5<sup>267</sup>. A study reported that while total economic costs of the patients, suffering from mental disorder, were reduced, improvements over time in symptoms, disability and quality of life were observed<sup>278</sup>.

Using local trained counselors to provide mental health services has been cost-effectively demonstrated in post-conflict areas. The results of a study using the WHO criteria, indicates that interventions for CMDs (depressions and panic disorders) and epilepsy can be considered very cost-effective. These results are extremely applicable to mental health care programs in the community, because of lack of availability of mental health professionals in LAMI countries and post conflict areas<sup>261</sup>.

## **5.5 Suicide in the region**

There are many social, legal, and religious sanctions against suicide, so it is understudied and national rates of suicide are not known<sup>279</sup>. However, it is considered that suicide is high in societies that are socially isolated, mobile and disorganized<sup>280</sup>. The rate of suicide in Peshawar was reported as 0.21 per 100,000 per year. Males were the predominant victims with a male to female ratio of 2.9:1. The primary method used for suicide in both sexes was by firearm followed by hanging<sup>281</sup>. Another study reported crude rates of suicide in Peshawar to be 0.43/100,000 per year (average for 1991-2000)<sup>279</sup>. In a two-year analysis of all suicidal reports, men outnumbered women by 2:1. The majority of subjects were under 30 years of age. There were more single than married men, the trend was reversed in women and "domestic problems" was the commonest reason. Organophosphate insecticides were used by more than half the subjects, while psychotropics and analgesics were used infrequently<sup>282</sup>. A study conducted in Peshawar revealed that protective factors for suicide included responsibility towards family; religious beliefs; hope of improvement; survival & coping beliefs etc. in descending order of frequency<sup>283</sup>.

A study carried out in Afghanistan evaluating suicide during ten years (1955-1964) revealed a suicidal rate of 0.25 cases per 100,000 populations per year<sup>284</sup>. A more recent study indicates that women and girls in the age



range of 15-40, are attempting suicide in Afghanistan. It reports that an estimated 2300 women or girls were attempting suicide annually - mainly due to psychiatric illnesses, domestic violence and/or socio-economic hardship<sup>285</sup>.

## **5.6 Beliefs about CMDs in the region**

A study in Pakistan highlighted the lack of awareness of the concepts of mental illness where 50% of the medical students and professionals had not even heard about depressive illness and a significant proportion had a negative attitude towards depressed patients<sup>286, 287</sup>. One study which explored the feelings of stigma among patients attending a psychiatric service found that 47% of the patients felt stigmatized. Males and people from urban areas felt more stigma but it was statistically insignificant. Education level was found to increase feelings of stigma<sup>288</sup>.

In countries like Afghanistan, with poor healthcare system, the neglected provision of mental healthcare services, and suffering of patients mostly due to stigma associated with mental disorder, mean that many patients never get a diagnosis, and continue to suffer inhuman practices. The use and abuse of illicit drugs in association of mental illness, is another factor that indirectly contributes to the maintenance of mental health stigma.

## **5.7 Management of CMDs in the region**

The management both pharmacological and psychological is discussed under this heading.

### **5.7.1 Pharmacological Management**

Pharmacotherapy is the main treatment for CMDs in this region, mostly in the form of antidepressants. A look at the local pharmacopeia shows that antidepressants, especially tricyclics, are not expensive in the region. Still, there is evidence that non-compliance to medication is high and that non-affordability of medication is the main reason for this. One study screened 343 psychiatric outpatients and among them 56 (16.32%) had stopped their medication with non-affordability as the commonest cause for discontinuation<sup>289, 290</sup>. In a similar study which involved 200 follow up psychiatric patients, the commonest reasons for non-compliance were unawareness of the benefits of treatment (43%), non-affordability of drugs (33.5%), physical side effects (28.5%), etc. CMDs were the commonest, leading to non-compliance (31.5%)<sup>290</sup>.

Few original trials have been conducted to compare various antidepressants, in Pakistan, but none in the region under consideration.

### 5.7.2 Psychological Management

In view of the prevailing situation in the region and developing evidence base, psychological management has been proven to be one of the important pillars of management of CMDs. A randomized controlled trial assessed the onset and duration of benefit of counselling by minimally trained community counsellors for anxiety and/or depressive illness (CMD) in women of their own community, in a semi-urban community in Karachi, Pakistan. In the baseline survey, 366 cases were randomized to intervention and control arms. The intervention arm was re-screened for CMDs after 4 and 8 weeks of counselling and again 8 weeks after the last counseling session. As the results showed a significant benefit in the intervention arm, for ethical reasons, the controls were also counseled; and were screened in the same way. A significant reduction in the mean scores of both the groups was found after 4 weeks of counseling which further improved at 8 weeks. In the context of this study and keeping in view the current high prevalence and the stigma attached to psychiatric treatment in our communities, counseling at the basic health unit level could be an alternative strategy for the management of CMDs<sup>21, 291</sup>.

A study in Kabul evaluated the role of psychosocial group counseling with Afghan women and showed it to be a useful intervention to assist Afghan women suffering from a variety of emotional or physical problems as over

90% of the participants described an improvement in their general health or social life<sup>292</sup>. A study by Mehraby N have proven the role of counseling in Afghan women in Australia using Bicultural counsellors, as majority of over 1200 women who used the service are leading productive lives in Australia<sup>293</sup>.

Rahman and colleagues have described a CBT-based intervention which they integrated into the routine work of community-based Lady health workers (LHWs) in rural Pakistan and assessed the effect of this intervention on maternal depressive illness and infant outcomes<sup>294</sup>. They reported that they had modified the intervention using qualitative methods to adapt it to the local needs<sup>295</sup>.

Our group has culturally adapted CBT in Pakistan and tested its efficacy in CMDs and other psychiatric disorders, through many studies. Preliminary evaluation of adapted CBT found it to be effective in primary care settings<sup>296</sup>. We conducted a larger randomized controlled trial (RCT) to demonstrate that a brief version of this culturally adapted CBT was more effective than ‘treatment as usual’. Participants in intervention group showed statistically significant improvement in depression ( $p=0.000$ ), anxiety ( $p=0.000$ ), somatic symptoms ( $p=0.005$ ) and disability ( $p=0.000$ ). Participants in intervention group also reported higher satisfaction with

treatment compared with those in Control group<sup>297</sup>. A multi-center randomized controlled trial also found a culturally adapted, CBT-based (CaCBT) self-help intervention to be effective<sup>298</sup>. Another pre-post study with patients on OCD using CaCBT revealed that there were significant positive differences post CBT between the scores of Yale Brown Obsessive Compulsive Scale ( $p=0.000$ ), Hospital Anxiety and Depression Scale – Depression subscale ( $p=0.001$ ), Hospital Anxiety and Depression Scale – Anxiety subscale ( $p=0.000$ ) and Brief Disability Questionnaire ( $p=0.000$ )<sup>299</sup>.

## **5.8 Summary**

High rates of CMDs have been reported in this region, being presented with somatic symptoms. Recent publications have highlighted the increasing rates of suicide. As far as management of depressive illness is concerned, mostly antidepressants are used for this purpose; rates of non-compliance have been described to be high and possibly non-affordability of drugs is one of the major factor. There is emerging evidence that psychological interventions, especially culturally adapted CBT based interventions, are effective in helping patients with CMDs. Therefore, due to these compelling reasons, we undertook this project of developing culturally adapted CBT in Pashto for people of the region, suffering from CMDs.

## **CHAPTER 6: DEVELOPING CULTURALLY SENSITIVE COGNITIVE BEHAVIOUR THERAPY (CBT) FOR PASHTO SPEAKING PAKISTANIS AND AFGHANS**

### **6.1 Background**

CBT has already established itself to be the most effective psychological intervention for a variety of illnesses including common mental disorders (CMDs) within developed countries. Evidence is being generated to support the effectiveness of the CBT for CMDs in non-Western, developing countries. Due to the availability of low cost human resources, psychological help, as an alternative to medication, may be less costly to provide with additional therapeutic benefits in many developing countries. Cultural factors are important in the application of psychotherapy as beliefs about the nature of illness and the likely effectiveness of interventions may vary. This means that a Westernized approach is likely to need modification to be optimally effective for other cultures<sup>21</sup>.

Focusing on the guidance from available research literature on developing new interventions and guidelines based on the experience of therapists working in the west with ethnic minority clients and utilizing the developed culturally adaptive CBT for Urdu speaking Pakistanis, this project was taken forward<sup>21</sup>.

The “Stage Model of Development of Psychotherapies” describes three stages which can be followed in establishing new therapies<sup>300</sup>. According to this model, generally the first stage is about pilot/ feasibility testing; manual writing; training program development; and therapist fidelity or adherence, for new and untested treatments. The second stage is about conducting controlled clinical trials to evaluate the efficacy of manualized therapy which has already been tested in a pilot project. In the third stage, generalizability and implementation strategies for psychotherapies need to be measured through at least two-stage clinical trials<sup>21</sup>.

Development of the complex intervention consists of the following steps; identifying the evidence base, identifying/developing appropriate theory and modelling process and outcomes. The above guidelines however are not intended for adapting therapy outside the Western Cultures but they focus on developing interventions in developed world. Therefore, the guidelines were used loosely and we planned a mixed method study with incorporation of both qualitative and quantitative research strategies, in order to develop, implement and evaluate the structure, process and outcomes associated with introducing a model of CBT in a given environment. It is worth mentioning here a framework which suggested a sequence for developing adaptations for ethnic minorities in the West, consisted of; (a) information gathering, (b)

initial adaptation designs (c) preliminary adaptation tests and (d) adaptation refinements<sup>301</sup>.

## **6.2 The reason for using CBT**

A relevant question here might be, given the significance of relationships in non-Western cultures, why Interpersonal Therapy (IPT) should not be used in these cultures, instead of the CBT? It can certainly be argued that psychotherapies such as IPT might be more suitable for non-Western cultures. IPT has an established evidence-base and an emphasis on work with relationships. However, the following factors helped us in choosing the therapy:

1. Relationships may not be the only or prime source of stress contributing to CMDs, in fact
2. In developing societies, the family has a more central role and will often be a source of support, in addition
3. Changing values in many non-Western cultures might mean the nature of relationships is changing,
4. CBT addresses relationships in addition to cognitions and beliefs. The cognitive model of the CBT clearly suggests that the focus of therapy is on patients' relationship with self; with others' and with future.
5. CBT has an established evidence base and is the most researched psychotherapy



6. Evidence has suggested that CBT can be used in non-Western cultures and especially that it has been tried in Pakistan by our group.

### **6.3 Research questions**

- How can CBT be adapted for use in Non-Western settings (e.g. for Pashto speaking Pakistanis and Afghans)?
- Is adapted CBT effective?

### **6.4 Aims of the study**

To develop a culturally adapted version of a Cognitive Behaviour Therapy Manual in Pashto for CMDs and to evaluate its effectiveness

### **6.5 Objectives of the study**

1. To identify those factors which need to be taken into consideration for incorporation into a CBT Manual for CMDs for it to be culturally sensitive
2. To develop guidelines which can be used to adapt a CBT for CMDs
3. To use a pilot study to establish whether such a manualized CBT delivered by psychology graduates after CBT training can reduce symptoms of CMDs.

## **6.6 Pashto CBT Project**

The project comprised of two stages. The first stage of the project comprised of development (drawing on the experience in the design of manuals by the applicants and the relevant literature)<sup>302</sup> and adaptation of a CBT manual (evidence base, new knowledge generated through a series of studies; interviews with patients, carers, mental health professionals and students, all of these led to the development of a theory in the form of an adaptation framework, which guided us in the making of the manual). In the second stage a pilot project was conducted.

### **6.6.1 Stage 1- design and development of a CBT manual for CMDs**

It was decided that any method to investigate the issue in hand (i.e., what should be done to culturally adapt CBT) should include all the major stake holders. Thus it was important to know through interviews what patients (and carers) think of their illness, its causes and its treatment, in particular of psychotherapy. It also included talking to local mental health professionals who were providing psychological help, about their experience of providing psychotherapy and if possible CBT. This might help to elicit culture and working practices; including values and norms, rituals, reward systems, formal and informal communication structures and organizational symbols. This knowledge could then be used in drawing principles which might be used to adapt CBT. A session with students was

conducted to get help in the practical Pashto translation of the terms used in CBT. Once the relevant information was available from these small scale studies, a framework for adaptation was developed which was the basis of adaptation of the manual, written earlier at the start of the project.

#### **6.6.2 Stage 2 - pilot project to test the manual**

Once the manual was adapted, pilot project to field test the manual was carried out in primary care. The pilot project showed that mental health professionals can deliver therapy which was effective in reducing symptoms of CMD.

#### **6.6.3 Steps of the project**

In an attempt to adapt a CBT for CMD manual, the following steps were followed;

1. Review of the current literature on evidence base for psychological interventions for CMD illness, cultural adaptation of CBT and current picture of CMD research in the region
2. Planning the adaptation study- informed by ethnographic principles (see discussion on ethnography, under next paragraph, qualitative methods and data analysis) to elicit cultural factors
3. Generation of new knowledge (information gathering) using mixed methods studies: patients, carers, mental health professionals and students'

focus groups for translation

4. Literature search and development of adaptation framework  
(guidelines through the development of theory)
5. Adaptation of manual
6. Translation of manual into Pashto
7. Pilot project
8. Revision of manual

## **6.7 Qualitative methods and data analysis**

Methodology for each study will be described separately in the concerned chapter. Here the focus will be on the main issues and strategies used in the qualitative research within the wide context of the qualitative methods. The intention was to interview the small group of patients, carers and mental health professionals and conduct focus groups with students. Overall it was a mixed method study in which both qualitative and quantitative methods were used. In order to ascertain cultural factors, a modified ethnographic approach underpinned the first stage of the project.

### **6.7.1 Ethnography**

Ethnography has been defined as, “the descriptive study of a particular human society”. Contemporary ethnography is completely based on fieldwork and the ethnographer while living among the people (“subjects”),

cultivates close relationships with "informants" who can give information on various facets of cultural life. Direct, first-hand observation of daily participation is the commonest method of data collection in an ethnographic study. Interviewing (small talk to long interviews) is another common method.

#### **6.7.2 Interview as a research tool**

Interviews were used as the main tool for studies involving patients, carers and mental health professionals. It involved direct interaction with groups of respondents. The following stages were followed in designing and implementing studies involving patients, carers and mental health professionals:

- a. Thermalizing – the objectives of each study were decided as well as the topics to be investigated (for example, one topic in the study of psychologists' experience was "what barriers do psychologists experience in providing therapy to patients with CMDs?")<sup>303</sup>.
- b. Designing - The overall study design as well as the later stages of analyzing and reporting were planned. We planned open interviews with a list of possible topics to be covered. However, once we had interviewed with some patients, we realized that we needed a more structured approach and therefore we adapted our methods accordingly as the study proceeded.

- c. Interviewing - The interview is the instrument in this type of evaluation. Therefore, care need to be employed while conducting and recording the interviews. It was also decided to interview the participants in their hospitals/ institutes to ensure that interviews would take place at the agreed dates and times and at their convenience.
- d. Transcribing – All the interviews were transcribed in one sitting, soon after the session was over.
- e. Analyzing - Analysis of these interviews began as soon as these were transcribed.
- f. Reporting- Once the analysis was complete, the results were written for this thesis.

Names of the interviewees were not mentioned in any of these reports. We used open interviews to start with for both studies, however, we had a list of topics prior to the interviews, but we freely moved to areas which seemed to be pointing towards our overall aim of finding factors which could influence adaptation of CBT in Pakistan. In this way our method could be called a mixture of both open ended and interview guides approaches.

### **6.7.3 Analyses**

After gathering data from qualitative (patients, carer, mental health professionals and students study) and quantitative (pilot trial) studies, the

data was analyzed as and when a study was completed. All qualitative analyses involve: comprehending; synthesizing; theorizing; and re-contextualizing. The analysis begins with coding and categorizing and mainly involves techniques to search for themes, patterns and insights. NVivo 10 software was used to facilitate data analysis. Thematic content analysis (TCA) was used to analyze the data, which is the most basic type of qualitative analysis used to categorize the recurrent or common “themes”. Themes developed in this way were later used as guiding principles in adapting therapy<sup>304-306</sup>.

#### **6.7.4 Stages of thematic content analysis**

In order to analyze the data, the following stages were adopted <sup>304</sup>:

1. The process started with preparing transcripts of the interviews. Before beginning thematic content analysis, multiple copies of interview transcripts were made and these transcripts were read many times before starting the actual analysis.
2. All relevant descriptions were marked with different coloured highlighters. Each interviewee was assigned a number/ coder and each line in a transcript was also given a number.
3. Each distinct unit of meaning (code) was marked from the highlighted areas. Meaning units were separated distinguished through

different colour. These units varied in text length.

4. The units were cut out and similar units were put together in a pile. Each unit was coded according to the Interviewee number and the line number.

5. Each pile was labelled as initial categories (themes) using key words or phrases copied from highlighted texts. These categories were revised as we continued to code data.

6. The entire interview transcript was gone through to identify distinct units, grouping and regrouping similar and dissimilar units, and re-labelling categories as we went along.

7. All meaning units per category were read and were redistributed as appropriate as well as re-labelled categories as appropriate. At this stage some categories were merged into each other or subdivided.

8. After one to two weeks, the original interview transcripts were re-read and categories initially made were reconsidered. Further changes were made when appropriate.

9. Interviews were separately analyzed by another researcher (FN).

10. The same procedure was repeated for each interview transcript.

11. Once all the interviews in a given study had been analyzed in this way, categories/themes for all interview transcripts and notes were combined. Categories were collapsed or subdivided as appropriate. When it was considered necessary categories were re-labelled.



12. After a few days, total categories were re-read as a whole to make overall sense of the interview transcripts.

13. The process was repeated and involved a lot of contemplation and reflection and continued till the categories reflected the experience of the interviewees.

#### **6.7.5 Issues in qualitative research**

It is worth highlighting now some of the issues in qualitative research which we came across during the literature review, discussions with the colleagues and then during the supervision. Personal, conversational nature of interview situations highlighted many of the basic ethical issues of any research which we tried to be mindful of, while conducting this study<sup>304, 305</sup>.

1) Confidentiality - Because respondents shared very personal information, it was important to inform the participants that although their names and institutes would not be reported but their city will be. Fortunately, participants had no problems with this.

2) Informed consent – From the respondents, both verbal and written consent was obtained. They were also informed them that the interviews would be read by the research team, concerned.

3) Risk assessment – There were no major risks identified in this case. However, the names of the participants would not be disclosed.

## **6.8 Ethical approval**

The study received ethical approval both from Ethical Committee of FCM-New University of Lisbon and Prime Foundation Peshawar.

## **CHAPTER 7: INTERVIEWS WITH PATIENTS WITH COMMON MENTAL DISORDERS (CMDs)**

### **7.1 Background**

These interviews were conducted with patients with CMDs to explore their ideas about their illness and its treatment, especially psychological treatment. It has been suggested that CMDs with similar core symptoms across cultures, may have significant cultural variation in clinical presentation<sup>307, 308</sup>. Research on presenting complaints, diagnosis and prevalence of CMDs in these cultures have been reported<sup>309-314</sup>. Based on the knowledge of illness and beliefs about its treatment, help-seeking behaviours of the patients are shaped<sup>315, 316</sup>. Patients perspective is needed to be understood, if any effective strategies for the treatment have to be developed. For example, a study from the US reported that white persons find antidepressants more acceptable than African Americans<sup>317</sup>. Hispanics, on the other hand were likely to find counselling acceptable. The study found racial and ethnic differences in beliefs about treatment modalities but did not explain differences in the acceptability of treatment<sup>317</sup>.

There are a few qualitative studies of CMDs from the developing world which have described the essence of the patients' experience. A study in Dubai using focus groups reported stresses in the family and in the society;

relationships, lack of support etc. to be the causes of depressive illness and visiting religious places and speaking to religious professionals was the most effective coping strategy<sup>44</sup>. In another study, it was found that access to mental health care was made complicated by “somatization of emotional problems, variations in causal attribution between patients and their significant others, the nature of the available health care system and burden of infectious disease”<sup>318</sup>. A Brazilian study showed that depression in women was linked to their day to day suffering<sup>319</sup>.

Very little is known about patients’ views of their illness and its treatment despite the fact that very high rates of CMDs have been reported in Pakistan<sup>260</sup>. From the earlier work, it has been evident that only a small number of University students and doctors had some knowledge of depression<sup>246, 286, 287, 320</sup>. It was therefore decided to explore patients’ knowledge and beliefs using qualitative methods, in a similar way to researches conducted by our group previously with patients, having different culture and language<sup>21, 307</sup>. This chapter describes findings from our study in which we interviewed patients to see what they think about their illness, its causes, its treatment and specially psychotherapy.

## **7.2 Methodology**

### **7.2.1 Aims and Purpose**

- To ascertain patients' knowledge concerning CMDs.
- To find out their knowledge and their expectations regarding the health system, and to determine their perceptions of the received treatment, especially non-pharmacological treatments.

### 7.2.2 Areas Explored

We focused on the following topics during the interviews:

1. What are the common symptoms of their illness?
2. What do they understand about CMDs?
3. What they know/understand about treatment of their condition?
4. Whether they had seen any faith healers and what had been their experience with them?
5. What are their common beliefs about causes of their illness?
6. What are their beliefs about treatment or cure?
7. What do they see as the role of the mental health professionals?
8. What do they expect from psychiatrists/doctors?
9. What do they know about psychologists and their role?
10. What do they know about psychotherapy and its effect?
11. What do they think about medication?
12. How does this problem/ illness affect your life?

### **7.2.3 Sample and Settings**

A purposive sample was selected with the aim of identifying informants who would enable exploration relevant to the study. The sample was drawn from the outpatient service of Psychiatry Department of a teaching hospital of Peshawar. Psychiatrists running the outpatient clinic were asked to assess patients for fulfillment of inclusion criteria (i.e., a diagnosis of CMD, age 18 years and above, disease history of more than a year, and absence of psychosis, mental retardation and substance/ alcohol abuse) and refer. Once referred these patients were given information regarding the study. Those who consented were included in this study. None of the patients declined to participate, with consent being taken in both the verbal and written form. They were interviewed again using International Classification of Diseases, 10th Edition, Research Diagnostic Criteria<sup>59</sup> to confirm the diagnoses by MI, who carried out all the interviews. To enable us to adequately understand the experience of patients with mental health services, those who had attended at least 2 psychiatric appointments, were selected. Interviews were conducted in 2 groups (one, each day). Colleagues were asked to refer the first patient they saw with CMD that day and then every fourth patient afterwards.

### **7.2.4 Design and conduct of study**

We interviewed patients from the psychiatry outpatient clinic of a teaching hospital in Peshawar. Peshawar is the capital of Khyber Pakhtunkhwa and the 9<sup>th</sup> largest city of Pakistan. The city itself is administratively subdivided into 4 towns and 93 Union Councils (the union council is the smallest administrative unit in Pakistan). It is situated in a large valley near Pak-Afghan border. The recorded history of the city dates back to at least 539 BC, making it one of the oldest city in South Asia. According to Tertius Chandler who was a famous historian, in the year 100 AD, Peshawar consisted of a population of 120,000, making it the 7th-most populous city in the world at that time. It has been named again and again till the current name, Peshawar. The area of Peshawar is 1257 km<sup>2</sup> (485 square miles). An estimated population of the city as per the assessment in 2014 is 1755000<sup>321</sup>. The city has university campuses, many public and private medical colleges and numerous private and public sector colleges. Peshawar is accessible through road, train and air routes. People can speak Urdu, Pashto and Hindko languages. Most people are bilingual. Although majority of people are Muslims, a minority of Sikhs and Hindus also live in Peshawar.

This qualitative study was conducted with the aim of developing an understanding of CMDs from the patients' point of view by exploring how people diagnosed with these CMDs conceptualize their illness and what do they know about its management, especially non-pharmacological

management. Although the central question was “what do patients know about (and if they do, what do they think about) non-pharmacological interventions for CMDs (especially CBT)?” It was felt that it is essential to explore their knowledge of CMDs, its causes and its treatment in general terms, before specific questions could be asked about non-pharmacological treatments. A total of 16 patients were interviewed in two groups (n=7 and n=9). Interviews were carried out until new themes stopped emerging and the data were saturated.

#### **7.2.5 Data Analysis**

Interviews took place in October- December 2015. All the interviews were tape recorded. Interviews were conducted in Pashto. Interview notes were hand written for analysis. The interviews lasted for between 60 to 90 minutes and were undertaken in the department of psychiatry of the teaching hospital. All the interviews were translated into English. Data collection and analysis were performed simultaneously, and recruitment of participants were ceased once no new information relevant to the main purpose of this analysis emerged. All the transcripts were repeatedly read to develop codes and identify main themes relating to the aims of the study. NVivo 10 software was used to facilitate data analysis. NVivo is anticipated to let users classify, sort and arrange information; examine data, finding relationships; and combine analysis with linking, searching, shaping and



modeling.

The analysis of the interviews was completed using a qualitative descriptive design. This involved developing codes using thematic content analysis methods, based on the comparison of data from each interview and subsequent grouping of these codes to represent main themes. The analysis was intended to be descriptive and involved minimal interpretation of the data. Credibility was ensured in the analysis, by involving other team members independently who coded the transcripts, and these codes were compared with those identified by MI. No alterations of, or additions to, the main themes originally identified were considered necessary. The statements that illustrate the main themes are presented in the results<sup>304-306</sup>.

### **7.3 Ethical issues**

All the patients gave consent both in writing and verbally. Consent was confirmed through the relative who was accompanying the patient, for uneducated patients. Ethical approval of the study had been granted by the Ethical Committee of FCM- New University of Lisbon and Prime Foundation Peshawar.

### **7.4 Results**

Of the 16 respondents, six patients were male. The age of the sample ranged

between 18 to 50 years with a mean age of  $27.68 \pm 9.99$  years. One patient was a Network Engineer; two had bachelor's degrees, eight had varied level of schooling and five patients had no formal schooling. Seven of these were married. Five of them were local residents while the rest came from other cities including one who came from Khost, Afghanistan. The history of illness ranged between 1 year to more than 20 years. All were treated by the doctors (in primary or secondary care). All the patients who met criteria for depressive illness according to the ICD10, RDC, also suffered with significant anxiety symptoms.

The Findings are presented in six themes: (1) Their perception of their illness and its impact on their lives (2) their model of causes of their illness (3) their model of referral (4) the treatment of their illness; and pertaining to general knowledge about mental illnesses, (5) their knowledge and perception of mental illnesses and (6) their treatments.

#### **7.4.1 Patients' perception of their illness and its effect on their lives**

Patients complained of physical symptoms a lot. For example, apart from obsessions, they complained about headache, sleep disturbances, weakness, breathlessness, palpitations, restlessness, tiredness were the complaints that led them to seek treatment. Other complaints included, burden on head, being unconscious, crying, anger and sadness. Only two patients described

sadness as the first complaint. Four patients didn't know what is wrong with them while 6 knew their exact diagnosis. Obsession was the commonest complaint.

*“There are thoughts which come again and again and these disturb me. These disturb my sleep and I feel weak (P-7).”*

*“There are a lot of obsessive thoughts and these thoughts give me continuous headaches. I wish these thoughts were not there (P-15).”*

When they were asked the nature of the illness they described it to be somatic, expressing it to be ‘weakness/ illness of brain’ and ‘tension’. Only six patients use specific name for their illness.

On the other hand, when patients were asked to choose between having a physical or mental illness, all (n=16) opined it to be a mental illness. Only three patients thought they also have a physical illness.

*“Apart from being mental illness, it is physical in nature as well as it has affected me in a way that it has led to*

*weakness of the whole body (P-1)."*

*"It is both Physical and mental because it affects mind and body both (P-14)."*

However, when asked before this question whether they know anything about CMD, only two answered in affirmative.

All the patients claimed that their illness has negatively affected their lives but told that they had to keep performing their specified roles in lives, to make the ends meet. They were sure that the illness had affected their ability to work and led to social isolation, problem in decision making and stigma. Two of them reported stopping his or her duties or responsibilities. Two remarked;

*"My studies have been affected and I can't memorize the lessons of school. This led to dropping off the school. (P-15)."*

*"I feel isolated, extremely tired, developed self-pity and my life has become different than other normal people living around me. (P-16)."*

#### 7.4.2 A psycho-social model of causes of CMD

The patient's ideas about the cause are important, since they have important implications in treatment and follow up. Four of them didn't know the cause of their illness. Remaining twelve described social problems, problems at home and work to be the cause of the illness. One was convinced that these are due to supernatural and the other believed in genetic predisposition.

*“All these symptoms are due to supernatural powers. Our house has been a haunted house and I have got this problem due to living in this house (P-6).”*

*“My father was suffering from the same and this has transmitted to me, from him, because these illnesses are genetic in nature (P-1).”*

#### 7.4.3 Referral to the psychiatrist

Four patients referred themselves to the service. Ten were referred by a family member while two were referred to the hospital by local health practitioners (Doctor/ Nurse). They reported that,

*“I already knew all these symptoms are psychological in nature. So I came to the Psychiatrist, myself (P-7).”*

*“I consulted a local doctor in our village and he suggested that this is a psychological illness and referred me to the Psychiatry department of the hospital (P-3).”*

#### **7.4.4 Treatment of CMDs**

The aim of this query was to find out patients’ ideas about treatment. All of them (n=16) believed that they can get better with medicines. Three of them considered psychotherapy to be a valid treatment option.

*“All the doctors have only been prescribing medication. So I guess, medication is the only treatment (P-6).”*

*“Apart from medication, psychotherapy is also important. When the therapist sympathetically listens to the patient, it is beneficial to the patient (P-2).”*

Since we were particularly interested in their knowledge about treatment apart from medical treatment, eight told about the visit to a faith healer, three went to a religious scholar and one each to a Hakeem and Homeopathic doctor. However, all received treatment from a psychiatric facility.

All, except three were compliant with their medication. The reason for non-compliance in those three were “I got better, so I left medication”, “People told me to try to stay better without medication” and “I considered myself mentally weaker due to the use of medication”

#### **7.4.5 Patients’ knowledge and their perception of mental illnesses, in general**

While four patients said they don’t know anything about mental illness, others defined them as “illnesses due to tensions, problems in the thought and worries”. Their description of mental illness was based on whatever they heard from their peers. When directly asked if they knew anything about CMDs (explained in Pashto), everyone, except four, had at least a vague idea about it.

*“I have heard about mental illness. These are very serious illnesses (P-15).”*

The most striking thing was their failure to exactly name any mental illnesses. Most commonly named word was tension, while other names included mental worry and illness of sleep. Four patients used the term “tension” and only two used “anxiety and depressive illness”.

*“These symptoms are called anxiety and depression (P-2).”*

*“I think it is a disorder of thought. This is what they call it in our village (P-1).”*

Financial constraints, Social problems, Difficulties at work and home, thinking too much, etc. were the frequently described causes of mental illnesses. One of them said that it can be due to supernatural powers. Two patients also said mental illnesses can be due to genetic causes. Typical statements included;

*“There are a lot of social issues in our society like poverty and intolerance. This is the reason of mental illnesses (P-2).”*

*“Due to financial constraints, people develop mental illnesses (P-1).”*

#### **7.4.6 Treatment of mental illness, in general**

All patients believed that mental illnesses are treated by medications. Two patients had heard of counseling/ psychotherapy and considered it to be a



viable option for treatment. They all believed that “doctors, religious scholars (Alim) and faith healers (Pir) can treat CMDs”. Therefore, they emphasized on the role of education and religion. They all had strong faith in capacity of doctors in the treatment of mental illnesses. Only two of them had heard the name of psychologists as a profession. One of them, therefore expressed himself as,

*“There is a role of education and religion in the treatment of mental disorder (P-9).”*

*“There should be a psychologist in every school for regular assessment of children (P-2).”*

## **7.5 Discussion**

Interviews were conducted with patients attending the outpatient clinic of a psychiatric service in a teaching hospital in Peshawar, Pakistan. The gathering of information through interviews was not smooth as people were either reluctant to express their views or had no knowledge of CMDs. These findings confirm the previous work by our group where more than half of the participants said they had not heard of depression<sup>246, 307</sup>. Patients appeared guarded and careful when answering the questions regarding treatment, particularly non-medical treatments probably to avoid

“annoying” the doctors<sup>307</sup>.

Most patients presented with somatic complaints which is a common finding in literature, even core symptoms such as depressed mood or loss of interest may not be among the presenting complaints in many cultures<sup>7, 307</sup>. Obsession was the commonest complaint followed by headache. Patients called their illness “illness of tension”. A few considered it to be physical and possibly a brain disease. It was noted that the words “tension” and “mood” were commonly used by both Pashto speakers. Although on closed ended questions most of the patients said it is a mental illness, they were cautious in saying the same when open ended questions were asked to explore the concept. This has also been noted in the literature<sup>307</sup>.

All of them said that their illness was affecting their lives. However, almost all carried on with their routine chores in lives as people have to perform their roles simply to survive and make ends meet. Similarly, females have to perform the duties as per their roles within the family, which has already been described in literature<sup>307</sup>.

Although all patients wanted medications, some of them describe their illness to be due to social and financial reasons, and problems at work/home. Therefore, a psycho-social model of understanding of CMDs is

comprehensible<sup>307</sup>.

We were unable to exactly find out how the process of referral works (as anyone can present himself to any hospital, in any part of the country) and why did patients (or in case of referral by a relative or friend) refer themselves to a psychiatric treatment facility, without having previous knowledge of mental illness? It seems that they are simply guided by the presence or absence of somatic complaints<sup>307</sup>.

We further proceeded with the interviews to include patient's views in general on mental illness but we could not get any additional information. Patients believed that the commonest cause of the mental illnesses is tension and that these can be treated by medicines only. The patients were hardly aware of the psychologists. Doctors were considered the only professionals who can give the right advice and therefore the ultimate authority regarding their treatment<sup>307</sup>.

Patients in the region probably knew very little about their illness and this impacts on their actions to seek help. This means that education of the patients is required regarding the illness and a shared understanding of symptoms should be developed<sup>307</sup>.

The unawareness of patients to non-pharmacological treatment should be considered while referring patients to psychologists. Sharing a formulation which uses a bio-psycho-social model of illness, while delivering psychological therapy to such patients, might be useful. Patient's concepts about mental illness in general were similar to their concepts about their own illness. This has already been confirmed in a previous study<sup>307</sup>. Similarly, some of the ideas in this study confirmed the findings from the interviews, conducted by our working group, with psychologists in Pakistan<sup>303</sup>.

## **7.6 Limitations of the study**

This study was conducted in a tertiary care service from a large city in Khyber Pakhtunkhwa, Pakistan. It is possible that patients in other parts of the country or in the community might have different opinions. The study also involved a smaller number of patients. Future studies similarly, talking to carers of the patients could give us a more thorough understanding of the issues around understanding of CMDs and their treatment. I should also point out that these are the patients who have come forward to seek treatment. They are likely to be different from people who suffer from the same problem and either seek help from other health professionals or even seek health from outside the traditional health system or do not seek help.

## **7.7 Conclusions**

Patients in the region have very little knowledge of their illnesses. They also don't know very much about non-medical treatments of mental illnesses. Although they considered psychosocial stressors as cause of mental illnesses, still they felt that their somatic symptoms should be treated with medicines. The study also confirmed and triangulated some of our earlier findings when we interviewed psychologists (for example somatic presentation, patients not being aware of non-psychopharmacological treatments etc.). This study highlighted the need to educate the patients and discuss with them treatment options and inform them of the role played by psychological interventions in the treatment of CMDs and allow them to choose from these options. The study, like previous studies highlighted three areas which we need to focus on, in order to modify therapy in the region, i.e., cultural considerations (for example patients' use of non-traditional healing methods), capacity of the system and the individuals (for example pathways to care including the process of referral) and patients' cognitions and beliefs (their model of illness, what they think about the treatment of CMDs)<sup>307</sup>.

## **CHAPTER 8: INTERVIEWS WITH CARERS OF PATIENTS WITH COMMON MENTAL DISORDERS (CMDs)**

### **8.1 Background**

These interviews were conducted with carers of patients with CMDs to explore their ideas about the illness and treatment, especially psychological treatment of their patients. Carers have an important role in the treatment of patients with CMDs. The social fabric of this region has given the patients a luxury of the availability of carers, even full time, without direct financial implications<sup>322</sup>. Not to forget that the treatment of female patients is partially or fully dependent on the support of family members i.e., carers<sup>323</sup>. Patients' help-seeking behaviours are influenced by negative reinforcement from the family especially the carers<sup>324, 325</sup>. In order to develop effective strategies for the treatment of these patients, we can't ignore the important role that the carers can play and we must make them a partner in the treatment plans to work for the improvement of patients<sup>326, 327</sup>.

There are a few qualitative studies of CMDs from the developing world which have described the essence of the carers' experience<sup>328, 329</sup>. A qualitative study reported that carers feel that distress, anxiety, depression, sleep disturbance, loss of interest, disturb eating habits, trauma and stress are the key symptoms of CMDs<sup>330</sup>.

Despite high rates of CMDs<sup>260</sup>, very little is known about carers' views of the illness and treatment of their patients. A previous work of our group has shown that only a small number of doctors, and University students had some knowledge of depression, which is the major shareholder in CMDs<sup>246, 287, 320</sup>. It was therefore decided to explore carers' knowledge and beliefs using qualitative methods. This chapter describes findings from the interviews conducted with the carers to find out their perceptions about the illness, reasons, and treatment particularly psychotherapy, of their patients.

## **8.2 Methodology**

### **8.2.1 Aims and Purpose**

- To ascertain carers knowledge about CMDs.
- To establish their knowledge and their expectations concerning the health system, and to ascertain the perceptions of the treatment their patients' have received, especially non-pharmacological treatments

### **8.2.2 Areas Explored**

We focused on the following topics during the interviews:

1. What are the common symptoms of the illness of their patients?

2. What do they understand about CMDs?
3. What they know/understand about treatment of the condition of their patients?
4. Whether they have taken their patient to any faith healers and what had been their experience with them?
5. What are the common beliefs about causes of the illness of their patients?
6. What are their beliefs about treatment or cure of their patients?
7. What do they see as the role of the mental health professionals?
8. What do they expect from psychiatrists/doctors?
9. What do they know about psychologists and their role?
10. What do they know about psychotherapy and its effect?
11. What do they think about medication?
12. What has been the effect of illness of patient on family member/carer?

### **8.2.3 Sample and Settings**

A purposive sample was drawn from the outpatient service of Psychiatry Department of a teaching hospital of Peshawar. Psychiatrists running the outpatient clinic were asked to refer carers of patients who fulfilled inclusion criteria (i.e., their patients had a diagnosis of CMD). Once referred these were given information regarding the study. Those who consented



were included in this study. None of the referred carers declined to participate, with consent being taken in both the verbal and written form.

#### **8.2.4 Design and conduct of study**

We interviewed patients from the psychiatry outpatient clinic of a teaching hospital in Peshawar. The geographical description has already been mentioned under 7.2.4.

This qualitative study was conducted to understand carers' point of view by exploring how carers of people with established diagnosis of CMD conceptualize the illness of their patient and what they know about its treatment, especially non-pharmacological treatment. Although the central question was "what do carers know about (and if they do, what do they think about) non-pharmacological interventions for CMDs (especially CBT)?" It was felt that it is essential to explore their knowledge of CMDs, its causes and its treatment in general terms, before specific questions could be asked about non-pharmacological treatments. A total of 16 carers were interviewed in two groups (n=6 and n=10). Interviews were carried out until new themes stopped emerging and the data were saturated.

#### **8.2.5 Data Analysis**

Interviews took place in October- December 2015. All the interviews were

tape recorded. Interviews were conducted in Pashto. Interview notes were hand written for analysis. The interviews lasted for between 60 to 90 minutes and were undertaken in the department of psychiatry of the teaching hospital. All the interviews were translated into English. Data collection and analysis were performed concurrently, and recruitment of participants were ceased once no new information relevant to the main purpose of this analysis emerged. All the transcripts were repeatedly read to develop codes and identify main themes relating to the aims of the study. NVivo 10 software was used to facilitate data analysis. NVivo is anticipated to let users classify, sort and arrange information; examine data, finding relationships; and combine analysis with linking, searching, shaping and modeling.

The interviews were analyzed by a qualitative descriptive design. This involved developing codes using thematic content analysis methods, based on the comparison of data from each interview and subsequent grouping of these codes to represent main themes. The analysis was intended to be descriptive and involved minimal interpretation of the data. Credibility was ensured in the analysis, by involving other team members independently who coded the transcripts, and these codes were compared with those identified by MI. No alterations of, or additions to, the main themes originally identified were considered necessary. The statements that

illustrate the main themes are presented in the results<sup>304-306</sup>.

### **8.3 Ethical issues**

All the carers gave consent both in writing and verbally. Ethical approval of the study had been granted by the Ethical Committee of FCM- New University of Lisbon and Prime Foundation Peshawar.

### **8.4 Results**

Of the 16 respondents, four were females. The age of the sample ranged between 18 to 60 years with a mean age of  $41.0 \pm 14.75$  years. One carer was MBA and another did Masters in Arts; Eight had varied level of schooling and six carers were illiterates. Only two were unmarried. Six of them were local residents while the rest came from other cities including one who came from Kabul, Afghanistan.

The Findings are presented in six themes: (1) Their perception of illness and its impact on their lives and the life of their patients (2) their model of causes of illness of their patients (3) their model of referral (4) the treatment of the illness of their patient; and pertaining to general knowledge about mental illnesses, (5) their knowledge and perception of mental illnesses and (6) their treatments.

#### **8.4.1 Carers' perception of illness and its effect on their lives and the life of their patients**

Carers were concerned mostly about the episodes of unresponsiveness of their patients and the tension felt by their patients. Other symptoms mentioned by the carers were headache, aggression, vertigo and a state of pre-occupation. They also perceived the illness of their patients as having the feeling of suffocation, anxiety, and possession by supernatural powers. No one knew the exact diagnosis of their patients.

*“My sister has sudden episodes of unconsciousness and she does not make any sense when she talks after regaining her consciousness (C-3).”*

*“My niece is worried about her father's illness and gets tense which leads to her presenting condition. (C-8).”*

When carers were asked what kind of illness their patients had, seven of them had no idea about it while two considered it as mental illness. One mentioned that their patient has been under the influence of evil eye.

However, when carers were asked whether their patient had a physical

illness or mental illness, only 3 replied that it was a mental illness and 11 were not sure about the nature of the illness of their patients.

All the carers admitted that the illness has affected the lives of patients and family members/ carers except one. They gave different version of the effect including the fact the patients are even unable to do daily chores and there have been disconnect in the education of the patients.

*“Due to the current condition of the patient, the whole family is sad and disturbed (C-4).”*

*“It does not any make any difference. We are used to it. However, the memory of the patient has been affected (C-1).”*

#### **8.4.2 A psycho-social model of causes of CMD**

The carers' ideas about the cause are important due to the fact they can be utilized as a partner in the treatment of their patients. Only one of them didn't know the reason for the illness of their patient. Five of them described tension due to psychosocial issues as the cause of their mental disorder. Two of them considered it to be genetic while another two considered it to be due to magic. One described it to be due to supernatural

reasons.

*“Psychosocial stressor like conflict with the fiancée is the cause of the mental illness of my patient (C-6).”*

*“We have taken our patient to many places and now we are convinced that her illness is due to the cast of magic and taweez done on her by someone receiving our rejection on his proposal for her (C-2).”*

#### **8.4.3 Referral to the psychiatrist**

Thirteen carers reported that they themselves brought their patients to psychiatric service. Two patients were referred by a family member while one was referred by a local doctor. They reported that,

*“We took her to the local doctor in our village and he suggested that we should take her to a Psychiatrist (C-3).”*

*“There are psychiatric patients in the family and they suggested to visit a psychiatric facility (C-4).”*

#### **8.4.4 Treatment of CMDs**

The main aim of our enquiry was to ascertain carers' ideas about treatment of their patients. All of them (n=16) believed that their patients can get better with medicines. One of them considered psychotherapy to be a valid treatment option.

*“Our patient has received talking therapy and we were happy with the response of our patient to this type of therapy (C-1, C-5).”*

*“Dam Darood from Religious scholar is effective (C-4).”*

*“We took our patient to Hakeem who prescribed him medicines which consisted of particles of gold and silver (C-8).”*

*“My patient was given ECTs and he got better with that (C-13).”*

Since we were particularly interested in their knowledge about treatment apart from medical treatment, fourteen told about their visit to Religious Scholar (Alim) for “Dam Darood”, eleven told about the visit to a faith healer. Two of the carers informed that their patients received psychological

treatment as well. One each took their patient to Hakeem and Homeopathic practitioner.

#### **8.4.5 Carer' knowledge and their perception of mental illnesses, in general**

All the carers tried to describe common mental illnesses, however, they only had information about their own patients expressed in local language except one who described psychosis (not an illness of his patient) in local language by using the word “Wazam”.

*“Psychological Illnesses are all about Tension although I don't have an exact idea about these illnesses (C-6).”*

In our culture, common mental illnesses are referred to be due to possession of supernatural powers and this was expressed by one of the carers.

*“Mental illnesses are due to Supernatural (Jinnat) powers (C-13).”*

#### **8.4.6 Treatment of mental illness, in general**

All patients believed that mental illnesses are treated by medications. They all believed that “doctors, religious scholars (Alim) and faith healers (Pir)



can treat CMDs”. They described their thoughts on the approach of doctors and the role of psychologists in the treatment.

*“Patient gets better (30-40%) when the doctor is acting like a therapist (C- 14).”*

*“Psychologist have an important role in the treatment but unfortunately, they don’t fulfill their role (C-9).”*

## **8.5 Discussion**

Interviews were conducted with carers attending the outpatient clinic of a psychiatric service in a teaching hospital in Peshawar, Pakistan, along with their patient suffering from CMD. Carers play a vital role in supporting family members who are sick, unwell or disabled. There is no doubt that the families of those persons with mental disorders are affected by the conditions of their close ones. Carers not only offer practical help and personal care but also give emotional care and support to their relatives with a mental disorder. Therefore, the affected person is dependent on the carer and their wellbeing is directly related to the nature and quality of the care provided by the carer<sup>331</sup>. Carers were also more likely to report difficulties with debt and domestic violence<sup>322</sup>. According to Noble and Schenk, a few of the stressors that carers described, were due to the caring role and high

rates of trauma have been described in the carer populations<sup>332</sup>. Carers are also more likely to be the targets of aggressive behaviour, in case of serious mental illness<sup>333, 334</sup>. Anxiety disorders including Panic were most dominant among carers in recent studies<sup>317, 335</sup>. Fatigue, which can also be seen as a somatic symptom, has also been broadly described in carers<sup>331, 336</sup>. It is not very astonishing that carers stated about stressful life events. Primary stressors openly related to the caring relationship probably explain the relationship between caring, mental disorder and Personality characteristics and coping styles of the caregiver<sup>337-340</sup>. This should also be useful to include in future surveys<sup>31, 341</sup>. Furthermore, about 4% of the sample admitted suicidal thoughts in the previous year. Suicidal ideation has been reported dementia carers<sup>342</sup>.

In our study, carers were concerned about episodes of unresponsiveness and perceived the illness in terms of somatic and psychological symptoms. They also considered spirit possession, when they were asked about their knowledge of what has happened to the patient. One of the study on carers perception about mental illness found that most attributed mental illness to brain disease, spirit possession and psychological trauma<sup>343</sup>. Some of the care givers described that these illnesses are because of jade and taweez, and according to them Dam Darood from Religious scholar was effective. A study conducted by Harshal et al, supported our finding and reported that a

quarter of the care givers suggested the role of evil spirits in the development of mental illness<sup>344</sup>. Similar conclusions have been reported in numerous studies<sup>345-347</sup>.

In our study all carers except one said that illness affected the lives of the patients and family members/ carers. They gave different version of the effect including the fact that the patients are even unable to do daily chores and there have been disconnect in the education of the patients.

In our study majority of the carer described that Psychologist have an important role in the treatment but unfortunately, they don't fulfill their role. One of the study by Pransky concluded that there is a critical need for psychologists to become more active in the prevention of mental health problems<sup>348</sup>. In preventing mental illness, a first step forward is building better understandings of the conditions affecting the nature, onset, and course of chronic mental illness<sup>349</sup>.

## **8.6 Limitations of the study**

This study was conducted in a tertiary care service from a large city in Khyber Pakhtunkhwa, Pakistan. It is possible that carers in community or those attending in other parts of the country might have different opinions. The study also involved a smaller number of carers. We must also take note

of the fact that these were the carers of the patients who have come forward to seek treatment and are likely to be different from carers who seek help from other health professionals or even seek health from outside the traditional health system or do not seek help.

## **8.7 Conclusions**

Carers in the region have very little knowledge of the illness of their patients. They also have inadequate know how about non-medical treatments of mental illnesses. This study highlighted the need to educate the carers and discuss with them treatment options regarding the illness of their patients and inform them of the role played by psychological interventions in the treatment of CMDs and allow them to think of choosing from these options, as well, while discussing with their patients.

## **CHAPTER 9: INTERVIEWS WITH MENTAL HEALTH PROFESSIONALS**

### **9.1 Background**

Based on interviews conducted with mental health professionals in the past, we found out that for catering individual needs of patients, experienced professionals already modify therapy, taking into considerations cultural and religious factors, like elsewhere<sup>21, 303</sup>. For example, it has been noted that the mental health professionals, working in the region, use customary religious practices as part of the therapy<sup>8</sup>.

Published literature from Pakistan indicates that the cost of medicines might prevent availability of effective treatment <sup>290</sup>. Since human resource in Pakistan is available at a low cost, it might be less costly to provide psychological help with additional therapeutic benefits or for the use as an alternative to pharmacotherapy.

Most universities in Pakistan, whether private or public, have a psychology department and offer both bachelor (BSc) and master (MSc) programmes <sup>303</sup>. However, a university based postgraduate diploma is now necessary to practice in a public institute, as a psychologist. The training provided in postgraduate diplomas is mostly based on eclectic approach. There is no

uniform national system for accreditation or registration. The largest professional body for psychologists in Pakistan is Pakistan Psychological Society<sup>303</sup>. Our group has formed a sub specialty organization known as Pakistan Association of Cognitive Therapists, which is gaining popularity with the clinical psychologists. There are no similar organizations in Afghanistan and no reliable data is available regarding the teaching institutes.

To the best of our knowledge, no hospital in Pakistan has an established psychology department and psychologists hired (very limited in number) work as part of the medical team. Their job description also includes history taking and assessments in the outpatient clinics, where any patient from any part of the country can present himself/ herself for assessment<sup>303</sup>.

Most of the tertiary care hospitals in Pakistan have Psychiatry departments. These include public and private teaching institutes. Psychiatrists are employed to run these departments. For teaching institutes, a qualification of Fellowship from CPSP (or equivalent foreign qualification) is required. However, for working in primary care or district level hospital, qualification of Membership from CPSP; and Diploma in Psychological Medicine may be enough. These departments deal with all kind of psychiatric problems and apart from one or two exceptions, do not have any specific sub specialty

facility. There is one representative organization of psychiatrists in Pakistan called Pakistan Psychiatric Society which has almost 400 psychiatrists as members. No similar organization has been established in Afghanistan and no reliable data from Afghanistan is available regarding the presence of any available postgraduate qualification in Psychiatry.

This chapter describes the qualitative findings and implications of the received information through the interviews from mental health professionals. The study looked into identifying the factors which might need modification in the use of CBT in Pashto speaking population.

## **9.2 Methodology**

Instead of doing a survey, interviews were considered to be more effective in gaining information due to the fact that this was an unexplored area and the aim was to engage in a meaningful dialogue which could help to explore challenging issues (e.g., do local patients present with a different picture and how this difference is appreciated and addressed when applying techniques taken from the Western psychotherapy? and clarify any ambiguities or language nuances). The aims and purpose were kept similar to the study conducted by our group in 2009, in another major city of Pakistan with psychologists only, having difference culture and language<sup>303</sup>.

### 9.2.1 Aims and Purpose<sup>303</sup>

“The aims of this study were to;

1. Elicit mental health professionals’ experience of therapy (particularly CBT) and/or their experiences of clients with common mental disorders (CMDs) for whom CBT might be an appropriate therapy; and
2. Identify factors that should be taken into account when developing therapy and the accompanying training manual for use with the Pashto speaking population.

The purpose of the interviews was to;

1. Ascertain how the mental health professionals help their patients with CMDs.
2. Gain a comprehensive understanding as to the kinds of therapy (including CBT) techniques therapists use that are acceptable to their patients
3. Discover whether the therapists employed any techniques that had been developed from local traditions<sup>303</sup>.”

### 9.2.2 Areas Explored

Drawing on the literature review and our group’s previous work (as mentioned before) and data from other studies conducted in difference countries, a list of important issues consisted of the following was



prepared<sup>303</sup>:

- “Background of the mental health professional (name, age, training, years of experience).
- Their area of work (adult/child, individual/group etc.).
- Their typical patient load and the proportion of patients who suffer from CMDs.
- What are the other problems with which patients present?
- How many sessions are usually provided to patients in routine therapy?
- The attendance and attrition rate from therapy sessions.
- Whether they find it easy to understand Western psychotherapy techniques especially those from cognitive therapy?
- Which techniques are used more often?
- Whether patients find some techniques unhelpful?
- The techniques patients prefer?
- Patients’ expectations of therapists?
- Elements of therapy, e.g. the role of the family and community?
- Distinctions in presentation of CMDs?
- Whether there is a need to modify CBT techniques for use in this region and if so, how? <sup>303</sup>” and
- What are the barriers providing these treatments and how they overcome these barriers?

### 9.2.3 Sample and Settings

The intended population of mental health professionals were practicing mental health in Khyber Pakhtunkhwa for at least 1 year. Mental health professionals were sought who preferably practiced CBT. However, it was soon apparent that they were only performing psychotherapy through Eclectic approach. Since eclectic approach also involves areas pertinent to CBT, we decided to proceed with the interviews<sup>350</sup>. Mental health professionals also informed that they were aware of the basic concepts of the CBT<sup>303</sup>. All contacted mental health professionals agreed to participate and provided consent. It was estimated that the sample size was likely to be in the region of 5-10 sessions of interviews with various groups of mental health professionals; or until data saturation was reached and no new themes emerged<sup>303</sup>. We did not need to go beyond our specified target as no new themes were being generated and the data was saturated.

### 9.2.4 Design and conduct of study

An interview guide was developed to ensure uniformity in our methodology. It incorporated the areas of interest regarding the study. Mental health professionals were asked regarding their experience of therapy with CMD patients. The study consisted of in depth interviews from mental health professionals (n=30). There were nine psychiatrists and 21 psychologists who were interviewed in 7 separate groups. All the mental

health professionals were interviewed (by MI) in their institutes. The interviews, conducted in English between October and December 2015 (widely used as a medium of teaching and spoken by health professionals) lasted between 60 to 90 minutes gathering information about the knowledge and practices of mental health professional. Anonymity and confidentiality were assured. To clarify points and emergent themes that arose from the initial transcriptions or analysis, few mental health professionals from the sample were contacted by phone. The verbatim interviews were analyzed by MI, NRA and FN for emerging themes. The themes were then converted into codes. These were built into categories, in the final analysis<sup>303</sup>.

#### 9.2.5 Data Analysis<sup>304-306</sup>

NVivo 10 software was used to facilitate data analysis. NVivo is anticipated to let users classify, sort and arrange information, examine data, finding relationships, and combine analysis with linking, searching, shaping and modeling. Interviews were analyzed using thematic content analysis. Transcription of interviews started simultaneously with the start of interviews. The interviews were transcribed by the primary researcher (MI). These interviewees were ascribed numbers which were used in the transcription and writing the results. Three of the research team (MI, NRA and FN) read transcriptions thoroughly as soon as these were available. They identified topics of interest (open codes) either due to their existence

in literature or due to their importance in relation to the areas, our study wanted to explore. The authors worked on this separately and exchanged notes through emails. Regular meetings were held to discuss emerging themes, concepts and conflicts. These separate readings were compared and discussed in details throughout the period of study. This facilitated in constructing a synthetic set of codes leading to guidance regarding next interview and the overall analysis of the transcripts. This process was repeated, which resulted in modification of the working codebook till a final set of codes was obtained. The process stopped at reaching the saturation point where it was realized that no new themes were emerging. Finally, the data were reorganized into wider themes and categories; and written for this chapter.

### **9.3 Ethical issues**

All the mental health professional gave consent both in writing and verbally. Ethical approval of the study had been granted by the Ethical Committee of FCM- New University of Lisbon and Prime Foundation Peshawar.

### **9.4 Results**

Thirty mental health professionals who were interviewed, comprised of 21 psychologists (all females) and 9 psychiatrists (all males). This is due to the fact that in Peshawar, psychiatrists are mostly males while psychologists are

mostly females. The mean age of the sample was  $32.13 \pm 5.7$  years. Seventeen were married. Their experience ranged between 1 to 16 years with a mean of  $6.11 \pm 5.71$  years. They all had a postgraduate qualification. All of them reported being aware of CBT techniques. They worked in both public and private facilities. While they all (except one) worked mainly as government employees, psychiatrists also worked in their private clinics in the evenings.

Mental health professionals reported that anxiety and depression are the commonest diagnoses in their practice (more than 70% of the patients see their mental health professional, with symptoms of anxiety and depression).

#### **9.4.1 Issues related to pre therapy situation**

##### **9.4.1.1 Service issues**

In the region under study, the health service, in general, is inadequately structured and specialist services are only limited to the big cities. Mental health services are no different. Patients usually consult their mental health professional in the outpatient services. They are also referred from Accident & Emergency departments in the hospital which was the most commonly reported mode in our study ( $n=7$ ). Also, there were referrals from friends and family ( $n=7$ ), and self-referrals from patients ( $n=9$ ). Patients attending

the public hospitals are usually from a weak financial background, not well educated and come from distant places. According to one mental health professional, majority (More than 70%) of the patients came from outside the city of Peshawar. Patients visiting mental health professionals in their private practices might be sound financially and well educated. However, the outcome of the therapy for those who live locally, are educated and come from an affluent background is not entirely different from the rest. This got apparent during later discussions.

*“(We) feel that health system has failed to generate resources which are required due to the increase in the number of patients. These should have been in terms of infra structure, human resources and appropriate allocation of available resources pertaining to metal health (M-5, M-21, M-26 & M-28).”*

*“There has been a lack of connectivity between mental health professional i.e., psychiatrists and psychologists (M-7).”*

Since the number of psychiatry departments is much less than required, the patient load is very high. This obviously means that mental health

professionals have to offer consultation to a greater number of patients for therapy, than the usual international norms. One mental health professional told us that,

*“On the Out Patient Day, I have to see more than 40 patients and every second day is our Out Patient Day (M-18).”*

Mental health professionals (n=13), reported that half of the patients drop out after few sessions. The drop outs are higher for patients coming from outside Peshawar; however, there were other factors too, responsible for high dropout rates.

*“Young patients particularly students cannot afford time due to their studies or work to come for follow up (M-5).”*

*“Patient coming from outside Peshawar hardly follow up for one or two sessions (M-5). Apart from distance, socioeconomic status, and patient not believing in psychotherapy are other reasons for drop outs (M-15).”*

*“Patients stop coming as soon as they are improved (M-*

19)”

#### 9.4.1.2 Dealing with somatic complaints

Patients present with a wide variety of diagnoses, but mostly present with somatic symptoms (n=30). One professional described that

*“Sometimes the CMDs are due to social issues, financial constraints and interpersonal conflicts, but almost all our patients present with somatic complaints pertaining to aches and pains, gastric complaints and sleeping problems. It is difficult to tell them that they have no physical problem but only psychological problem, which can be helped by psychotherapy (M-25).”*

#### 9.4.1.3 Pharmacotherapy and psychotherapy

Mental health professionals told that almost always, patients receive psychological help in combination with pharmacotherapy. One mental health professional said:

*“Clients consider that psychotherapy is an add on to pharmacotherapy and may not be used alone (M-14).”*



while others talking on the same subject said:

*“Patients are more interested in medicines because for somatic complaints, they seek objective treatment and that is achieved with medicines (M-28).”*

#### **9.4.1.4 Homework**

This is a particularly difficult area with our patients (n=30). Some mental health professionals said that it might be due to lack of education. However, mental health professionals working in the private setup receiving educated patients also said that patients do not come back with completed homework assignments. According to one mental health professional:

*“Patients don’t follow homework assignments at all (M-7).”*

#### **9.4.1.5 Patient’s expectations from mental health professionals**

Patients expectations from mental health professionals are important in their help-seeking behaviours, adherence and follow-up with the therapy. As some of the mental health professionals said, it is possible that people probably expect medications from the medical system,

*“Patients expect to have improvement in their symptomatology (M-14). They are expecting only medicines from here (M-29) as they are interested in quick treatment for which they believe medicines are the solution (M-28). When we try to do counseling or psychotherapy, they feel it is only a chit chat although we are very purposeful (M-6)”.*

#### **9.4.1.6 Literal translation does not work**

Mental health professionals said that they find it difficult to explain even the basic term “psychotherapy” to the patient. When they try to tell them that it is a talking therapy, patients consider it to be useless.

*" There is no need to translate therapy manuals as therapists are aware of English. It is useless to do literal translation for the patients, unless the translation is based on cultural values and beliefs (M-26)."*

#### **9.4.2 Issues related to therapy**

##### **9.4.2.1 Assessment**

Assessment is done similarly to the practices used in the west. Most mental health professionals described the involvement of family in the assessment

process. Assessment includes history taking; formulating a management plan; and psychometric testing, if needed. The first step in therapy, therefore, is a careful assessment, as one mental health professional said;

*“(We) start the interview by asking about their problems and reach to a diagnosis, most likely a CMD. Patient mostly present with somatic complaints and the first step is to assess them both clinically and by the use of psychometric scale (M-16, M-21).”*

#### **9.4.2.2 Structure and content of sessions**

Depending on the patient, the number and length of sessions varies. Most mental health professionals said they usually plan 5-6 sessions (n=12). They said it is not always possible to follow a structured session but usually it starts with assessment, followed by decision about techniques to be used, implications, reassessment for change, family involvement and closure/termination. Describing the process of therapy, one of the mental health professional said

*“A therapy session can last between 45-60 minutes (M-8).”*

*“We do not follow strictly to the planned techniques as we*

*may need to change and employ new techniques, as and when needed, depending on the condition of the patient(M-5).”*

#### **9.4.2.3 Commonly used techniques**

Mental health professionals described frequent use of Problem Solving (n=21), cognitive restructuring (n=13) and relaxation (n=13) techniques.

They said:

*“(We) commonly use techniques such as problem solving, relaxation, cognitive re-structuring, mindfulness and Socratic questioning (M-7, M-15). We also use cognitive rehearsal, cost benefit analysis, reattribution, systematic desensitization and thought stopping (M-6).”*

#### **9.4.2.4 Techniques which patients find helpful**

Mental health professionals expressed that the patients find behavioural techniques easier to follow, in the beginning. They described cognitive restructuring (n=8), relaxation (n=4) and reattribution (n=4) to be more effective than other techniques.

*“Since most of our patients are having CMDs which have negative thoughts associated to it. Therefore, we mostly use cognitive restructuring to change their thoughts. This is beneficial to them and they improve a lot (M-1).”*

*“Patients presenting with somatic complaints like palpitations are helped by the use of relaxation techniques in the beginning (M-17).”*

#### **9.4.3 Style of therapy**

Mental health professionals said that the style of therapy is more collaborative (n=28). However, we did have a strong opinion advocating instructive style. Not to forget that all but one described that the patient expect an instructive style.

*“The patients like us to advise them on different issues. This is what they expect from us (M-18) but we try to stay collaborative (M-7).”*

#### **9.4.4 Involvement of the family**

All our respondents (n=30) describe that it is important to involve the family especially when the nature of the problem is of that sort and this

should be done with the permission of the patient.

*“In case of female patients, it is almost always difficult to engage them in therapy, if the male member of the family is not involved (M-2).”*

*“It is important to involve family because family members help the patient especially in homework assignments (M-5).”*

#### **9.4.5 Barriers in Psychotherapy**

Mental health professionals considered lack of experts (n=14), lack of awareness in community (n=12), and non-availability of proper environment for therapy (n=12) to be the major barriers. Not to forget stigma (n=7) and poverty (n=6) which may be stopping the patients to come to a mental health professional. They suggested that through awareness programmes in the community and producing experts in the field of psychotherapy will be the way out to overcome these barriers.

*“Since therapies are not usually a part of curriculum of Masters class in Psychology, therefore, psychologists are often not trained to do specialized therapies (M-27). Also,*

*our people are unaware about the existence of psychotherapy as a therapeutic entity (M-22)."*

#### **9.4.6 Differences in therapy**

All the respondents (n=30) believed that there is a considerable difference in the therapy done here as compared to the west and they referred it mostly due to the differences in culture (n=12) and linguistic differences (n=7).

*"All these therapies have an underpinning of western culture and language. These therapies are successful as such in the west as people in the west have an appropriate understand regarding the therapies, do not have affordability issues and have more therapists. We need to adapt these therapies in local languages in the light of our own culture (M-26)."*

### **9.5 Discussion**

This study was used to explore mental health professionals' experiences regarding the use of psychotherapy in their practice, particularly CBT, from a non-Western developing country. Since mental health professionals of the region are not trained in CBT (although they reported using CBT techniques during the interviews), it was necessary to interview mental health

professionals who were trained, even in other techniques. Therefore, some information was obtained regarding their experiences of psychotherapy, and an understanding was gained of how the psychological services work.

The investigation began by focusing on the content and style of therapy. It was soon evident that the content and style of therapy is dependent on the broader service and resource issues. The issues are structure, organization, delivery, and biological orientation of mental health services; and beliefs of the patients about mental health and the health system. As a result of exploration of these issues, therapy seemed to be more of a ritual instead of an attempt to change the situation. A similar pattern has been shown in a previous study<sup>303</sup>.

Specialist services related to mental health are concentrated in few big cities of the region and patients have to travel long distances to see the mental health professionals in these available services. Self-referral is common and there are no standard protocols for the process of referral. The treatment approach of the mental health system is biological. A psychiatrist give consultation to more than 50 patients per day in public sector hospitals. Similar findings have been reported in a study from Pakistan<sup>303</sup>.

As mentioned, people do come from distant places and, therefore, might not



be able to attend therapy sessions, regularly. So it is not unexpected that most patients do not turn up for follow up. However, mental health professionals said that even local patients even stop coming after a few sessions. Psychologists have expressed similar views, previously as well<sup>303</sup>.

Females are more likely to drop out as they are dependent on the male members of the family to be brought to the health facility or at least need to have permission from males, in our culture. Lack of financial resources and less availability of spare time were described as other possible reasons for poor follow up. It was also reported as soon as the patients are symptom-free, they stop attending therapy. A study reported that in addition to these factors, lack of proper support system between appointments; absence of written, audio or video material; and problems with completion of homework, also are responsible for poor follow up rate<sup>303</sup>.

Mental health professionals see a large number of patients for therapy. This can certainly affect the quality of therapy and a session that starts with assessment, may possibly ends with the assessment too. This has been a common finding<sup>303</sup>.

Somatic complaints are commonly reported in Asian patients with psychiatric problems and so is the case of the patients of the region. Somatic

presentation possibly explains why pharmacotherapy is more acceptable. However, it is not a straightforward issue. A study reported that patients with somatic complaints, frequently visit spiritual healers, who do not prescribe them medicines <sup>252</sup>. At the end of the day, a patient with mental health problems, presenting with somatic symptoms and being treated with medication might also have less stigma attached<sup>303</sup>.

“Homework” related problems are more frequently reported by therapists in the region, than in the west. Majority of the local mental health professionals consider illiteracy as a possible reason, while others believed that even educated patients don’t like to do written homework. This has been already reported in the literature<sup>303</sup>.

Language is obviously the main tool used to deliver psychotherapy. However, it should be noted that it is difficult even for the very educated, to understand psychological terminology in English and literal translation of psychotherapeutic concepts for use in a non-Western, developing, country might cause certain problems. Literal translations of cognitive errors were also described to be important hurdles in therapy. Similar problems have been shown in literature<sup>303</sup>. To address this issue, we had interviews with students and the details are given in the next chapter.

Patients overall prefer a style of therapy which is directive rather than collaborative. However, in our study, most mental health professionals favoured collaborative approach. This could be due to the culturally ingrained value of seeing a person in authority as the source of advice, support and enlightenment, shown in previous researches<sup>176, 188</sup>. This issue is addressed by involving a lot of suggestions, advice and support in the therapy. Not to forget that collaboration does not necessarily mean strictly following a Western model of equality of therapist and clients but to understand that at the end of the day, every therapy is based on educating the patient and use of Socratic dialogue, using techniques which rely on a teacher-student-like relationship. Mindfulness-based therapy, also works on a teacher-student model of therapy<sup>303</sup>.

Mental health professionals considered behavioural techniques to be useful. The frequent and successful use of relaxation techniques show the predominance of anxiety symptoms among local patients. Problem-solving and cognitive restructuring are other helpful techniques. Literature shows that depressive illness and anxiety are associated with social and relationship problems in Pakistan and this might be the reason of the success of above mentioned techniques<sup>234, 303, 351</sup>.

The family is considered to be a part of the therapy, apart from being a part

of the assessment. The family can be helpful in improving compliance and follow up as well as helping the patient in Homework assignments etc<sup>303</sup>.

Like reported previously, all the mental health professionals agreed that the therapy needs to be modified<sup>303</sup>.

## **9.6 Limitations of the Study**

Only mental health professionals working in psychiatry departments from Peshawar were approached. The interviews focused on issues which had previously been decided. This might have restricted us to discuss useful information on the topics that were not included in our list of ideas to be explored. However, care was taken not to ignore any useful cues as they emerged. Also, it was not possible to interview mental health professionals with specific training in CBT. Small sample size was a limitation but interviews stopped only when it was felt that new themes were not emerging.

## **9.7 Conclusions**

From our study's point of view, the most obvious thing was that therapy needs to be adapted. It also emerged from the study that any work to adapt should take into consideration the following wider areas; patients' beliefs (what do they think of CBT?), cultural needs of the patients (presentation of

symptoms, religion and spirituality) and limitations posed by the system of health and support, as well as individual differences particular to the culture of the region (for example, training in CBT, lack of mental health facilities and therefore distance people have to travel to see mental health professionals, number of patients seen by mental health professionals and gender differences in accessing the service). Six major themes emerged on analyses. These were: issues related to pre therapy situation; therapy related issues; style of therapy; involvement of the family; barriers in psychotherapy; and differences in therapy. Mental health professionals unanimously agreed the need of modification in the therapy to make it effective in our region. Issues related to structure and delivery of service, knowledge and beliefs of patients about health and therapy, were all found to affect therapy. This study has numerous limitations and this work needs to be repeated with improved methodology and with bigger sample size.

## **CHAPTER 10: GROUP DISCUSSION WITH STUDENTS FOR TRANSLATION OF TERMINOLOGY**

This chapter focuses on the translation of terminology into Pashto involving group discussion with students.

### **10.1 Background**

Translation and adaptation of terminology is an important part of the overall process of the adaptation of CBT. This was confirmed by mental health professionals who suggested that literal translations of terminology might be a hindrance in providing therapy in the region. Drawing on our previous work in Pakistan which included translation of a number of measurement instruments and translation and adaptation of the International Classification of Diseases, 10th edition, Research Diagnostic Criteria (ICD 10, RDC)<sup>59</sup>, we were aware of the problems and difficulties in this area<sup>352-354</sup>.

Pashto, which is the main language of the region under is an Eastern Iranian language belonging to the Indo-European family<sup>255</sup>. Further details can be found under 4.1 in Chapter 4.

Present day Pashto borrows words from other languages including English, notably when it comes to scientific terminology. Majority of the population

under discussion can speak Pashto and therefore we decided to choose Pashto as the language in which we were going to translate our work. However, we kept in mind the linguistic diversity and tried to choose terminology which was widely used and easily understood.

The use of words and associated grammatical rules from different languages makes Pashto a difficult language to translate into. It is therefore not surprising that there is a paucity of literature on psychological and psychiatric topics in Pashto. The methods and principles of translation in psychiatric literature have already been described<sup>20, 355-357</sup> albeit limited to measurement scales. One vital issue here is, “who can translate”. Our experience of translating scales and other relevant mental health information into Urdu suggests that translating psychiatric terminology is different from literary terminology. Therefore, apart from understanding both languages (original and target), understanding (or experience) of both cultures including cultural understanding of mental health related stuff, might be helpful<sup>358</sup>. Those translators who have learnt the language of the original version as a second language, are also recommended<sup>359</sup>. Others have stressed the importance of translators having good technical knowledge and full emotional understanding of both the source and the target languages; knowing about the cultural problems related to the concepts and terms used in the questionnaire; and having integrated knowledge of the area and

domains explored in the questionnaire<sup>360</sup>. Surprisingly, however, none of the published studies on this subject advocate the involvement of the end users in the translation process.

It is universally accepted that local idioms and phrases are easy to understand and remember (note the use of “black and white thinking” rather than “dichotomous thinking” in the UK, which is a concept most lay persons need no further explanation to understand). A technique was therefore adopted which we had already used in our previous work, which we termed “Name the title”<sup>21, 296</sup>. In this simple technique we described a concept to the participants in Pashto and asked the participants of the group to name it. We used the same technique to find out locally accepted and known equivalents of terminology (for example cognitive errors & dysfunctional beliefs). Since this study was conducted with students after the previous discussions, only relevant details from methodology are being described.

## **10.2 Methodology**

### **10.2.1 Aims and Purpose**

The aim of this part of the study was to find culturally relevant CBT terminology.



### **10.2.2 Areas Explored**

For this study we mainly focused on cognitive errors and other areas relevant to CBT terminology.

### **10.2.3 Sample and Settings**

Students of a department of Peshawar University were contacted through the head of department. Students were explained the purpose of the study. When agreed, the discussion was successfully arranged in the department with a total of 51 students.

### **10.2.4 Design and conduct of the study**

The “Name the title” technique was used with a group of students after informing them about the purpose of the study, i.e., finding out local terminology for the concepts represented by some of the terms used in CBT. They were never told the English term. Each term was explained with examples and then a short discussion ensued. Discussions were held in Pashto in a format that allowed students to interact and gave them a chance to discuss and clarify the ideas. At the end of the discussion we had several alternatives. Students were then asked to choose the one term which they considered most appropriate. The process was repeated for the rest of the terms. Here we will describe the alternatives we found for cognitive errors and some related terms.

### **10.3 Ethical Approval**

Ethical approval of the study had been granted by the Ethical Committee of FCM- New University of Lisbon and Prime Foundation Peshawar.

### **10.4 Results**

A total of 51 students participated. There were 3 (5.89 %) males and 48 (94.11%) females. The mean age in was  $21.98 \pm 1.28$  years, with a range of 20–26 years. There were 35 (68.65%) students from the Masters class, 7 (13.73%) students were doing their BS and 9 (17.62%) students were completing postgraduate diploma (after completing their Masters).

The following words or terms were offered as possible terms which could represent cognitive errors.

1. Black and white thinking: Mahdood soch (Limited thinking), Bay tarteeb soch (Disorganized thought), aar ya paar (either side of the river), Ya ba takht shi ya takhta ba shi (throne or execution).
2. Jumping to conclusions: ghalat fehmai soch (thinking style of misunderstanding), Marg na makhkay jara (Mourning before someone has died) Daz na makhkay ma mra (Don't die before you have been shot)
3. Overgeneralization: Tang nazar soch (narrow mindedness), Odraidalay soch (Static thinking), Haavi shaway soch (Pre occupied with

thoughts).

4. Selective abstraction: Paishan goyi kawal (Making predictions)
5. Magnification and minimization: Khabara Ziyatawal (to make a big thing out of a small one), Pesh na pesham khan jorawal (Making “lion” of on ordinary cat).

Note: The opposite can be considered for minimization.

6. Personalization: Har sa pa zaan/ sir aghashtal wal soch (Taking everything on your life), Zan malamata kwal (blaming yourself)

Some other words were also put forward for their response.

1. CBT: Soch au kirdaar tik kawalo nafsyati ilaaj (Therapy to correct thoughts and behaviour)
2. Cognitive Errors: Da soch ghatiyaanay (Errors of thought)
3. Negative Thinking: Tang nazar (Narrow minded), Land khoyi (Short tempered)
4. Fight or flight: Tora au talwaar (Use the sword or run)
5. Passive: Sara bala (Cold devil)
6. Aggressive: Jang babara (Ready to fight)
7. Manipulative: Bahanagir (Pretender)
8. Assertive: Rekhtanay (Truthful), Spina khabar kawal (Talking straight)
9. Let us agree to disagree: Sta akhpal soch zama akhpal soch (You have your

thoughts; I have mine)

10. Give and take: Sa gatalo la para ba sa belay (You have to lose some, to win some)

### **10.5 Discussion**

Initial discussions revealed that one of the barriers in therapy is unavailability of properly translated reading material and terminology in local languages. Psychologists found it difficult to convey their messages using literal translations of the terminology in English. It was felt that for terminology to be effective, it should be grounded in locally used idioms and expressions.

The “Name the title” technique proved to be useful in finding alternatives for cognitive errors and other relevant terminologies in this study. In another study, university students from social sciences departments were organized into focus groups and a similar technique was employed<sup>296</sup>.

When this terminology was used with patients they found it easy to understand and to remember.

### **10.6 Limitations of the Study**

Initially it was thought of as a limitation that students might be using

different terminology than the rest of the population. However, when terminology was used with patients they were comfortable with these and found them easy to understand and remember.

## **10.7 Conclusions**

The “Name the title” technique can be used in finding local alternative in a non-western culture. It can be used in small group discussions and does not need a lot of resources.

## **CHAPTER 11: THE PILOT PROJECT ----**

### **CBT IN PASHTO FOR COMMON MENTAL DIORDERS**

#### **11.1 Background**

The culturally adapted CBT manual in Pashto for common mental disorders (CMDs), after development, was put to a test through a small pilot trial. There are only few non-Western studies of effectiveness of CBT for CMDs. Nalini et al studied effectiveness of CBT in reducing depressive symptoms and negative thoughts in neurotic depressives by providing CBT to a sample of 25 clients for 25 sessions. The analysis of data of pre and post assessment revealed that therapy was significantly effective in reducing depressive symptoms as well as negative thoughts<sup>361</sup>. Similarly study by Richard et al described that patients receiving CBT showed improvement<sup>362</sup>. Another study of CBT for depressive illness among women with physical problems found that women receiving CBT showed improvement in mean scores on the factors of dependency, self-criticism and depression<sup>363</sup>. The first published trial of CBT for depressive illness was conducted in Hong Kong for treatment of chronic depressive illness against a waiting list in a group setting<sup>364</sup>. The therapy was provided in ten sessions with each session lasting for 2.5 hours. All terms that were to be used were translated into spoken language, worksheets were designed in Chinese and therapists emphasized on trying to find out and alter dysfunctional rules pertaining to

interpersonal relationships and family. The group leaders were particularly active in delivering therapy and delivered mini lectures throughout the therapy. A CBT trial conducted to treat antenatal depression (before the end of pregnancy) showed promising results<sup>365</sup>. One of the studies showed that recent CBT trials showed less improvement in the depressive symptoms as compared with the seminal trials<sup>366</sup>. Patients are interested in speedy improvement, and this may also increase the credibility of the treatment and motivation for further change<sup>367</sup>. Overall, efficacy of CBT for depression has been robustly supported<sup>368</sup> and its use as an adjunct to usual care (usually antidepressants) is effective in reducing depressive symptoms in this population<sup>369</sup>. However, this paper described only the trial of the intervention and not the process of translation of the CBT and its modification.

There are other non-Western studies which used CBT as part of the intervention. In one study of the CBT for medically unexplained symptoms in Sri Lanka<sup>370</sup>, CBT was compared with structured care. CBT was provided by GPs after short term training. Each patient received three mandatory sessions of CBT. Three more sessions were optional; however, uptake of the optional session was low, according to the authors. There was no difference between the two groups. Even if therapy was more effective than the structured care group, it would have been very difficult for the primary care

physicians to provide CBT in other developing countries due to heavy costs involved. A study from Pakistan used CBT as part of the intervention (CBT based psychological intervention) for mothers who were depressed and their infants<sup>295</sup>. Although the intervention was aimed towards helping the infants, CBT was found to be effective for depressed mothers. Therapy was provided by the lady health workers. They were trained for 2 days to deliver intervention and received monthly supervision in groups. Therapy was delivered in 16 sessions organized in 5 modules making the total period of delivery of intervention to be 11 months. The authors describe the lack of the involvement of a cognitive therapist to be a problem. They also highlight the problems of sustainability and feasibility of such programmes. Lady health workers working even in other areas might not be motivated enough to take on the extra work of delivering psychological interventions to women and their infants. In an another assessor-blinded, RCT on the efficacy of CBT in Pakistan on depressed patients showed significant reduction in scores of depression and anxiety<sup>297</sup>.

Similar projects for non-western population have proven culturally adapted CBT to be both acceptable and effective<sup>21, 296</sup>. Adapting a therapy that can be used in a variety of settings that has an established evidence base might prove to be the way forward for fulfilling the needs pertaining to mental



health, in an acceptable and cost effective manner. This chapter describes our pilot study.

## **11.2 Aims**

To assess the effectiveness of a “CaCBT intervention” for Pashto speaking patients with CMDs in Pakistan and Afghanistan.

## **11.3 Objectives**

The primary objective of the study was to see whether CBT adapted culturally and given using a manual is effective in reducing symptoms of CMDs as well as accompanying somatic symptoms and disability.

## **11.4 Methodology**

### **11.4.1 Design**

This randomized controlled trial was conducted in Peshawar, Khyber Pakhtunkhwa, between January and June 2016. The study aimed to assess effectiveness of a “CaCBT intervention” against care as usual for CMDs. Patients were referred for inclusion in the trial from the outpatient department of Mercy Teaching Hospital, Peshawar. Patients meeting the criteria were asked to join the study and written consent was sought prior to randomization. A total of 40 patients were recruited for the pilot study, with 20 in each arm of the trial. These were randomly assigned to two groups

following the standard randomization process which is described under 11.4.3. The intervention group (n=20) received “CaCBT intervention” in addition to the Treatment as usual (TAU). One person from the family was involved in order to improve compliance with therapy and follow up. The assessments were carried out at the base line and then at the end of therapy (7-12 weeks). Control group (n=20) received care (treatment) as usual. This usually means, contact with a medical professional and being on antidepressants. Blind raters were used to assess the change in depressive, anxiety and somatic symptoms, and disability using Hospital Anxiety and Depression Scale (HADS), Bradford Somatic Inventory (BSI) and WHO Disability Assessment Scale (WHO DAS 2.0). Schwartz Outcome Scale (SOS) was used only at the follow up to measure the outcome/ satisfaction with treatment. The trial was conducted in compliance with the Declaration of Helsinki and is registered at ClinicalTrials.gov Identifier: NCT02797691.

#### **11.4.2 Inclusion/exclusion criteria**

Patients with an ICD-10 (International Classification of Diseases) RDC (Research Diagnostic Criteria) diagnosis of CMD, with more than 8 score on depression and/ or anxiety subscale of Hospital Anxiety and Depression Scale (HADS), and living within traveling distance of the corresponding tertiary care hospital, were included in the study. Patients, who agreed to enter the study, were assessed to fill in the baseline measures when they

attended their first appointment. Patients were asked to attend a further appointment at the end of study period and were assessed again. The exclusion criteria included excessive use of alcohol or drugs (using ICD 10 RDC for alcohol or drug abuse or dependence) significant cognitive impairment (for example learning disability or dementia) and active psychosis.

#### **11.4.3 Randomization**

It was performed distantly by generating 10 blocks of 4, for this purpose. After randomization, patients were allocated to either CaCBT+TAU (intervention) or the TAU (control) arm. Randomization was performed using [www.randomization.com](http://www.randomization.com). The allocation list of the patients was kept in a distant protected place, and an independent person randomly allocated the included participants after they signed informed consent. Assessors were kept blind to randomization. The assessors informed the participants before each assessment that they should not talk about therapy or therapist.

#### **11.4.4 Instruments**

11.4.4.1        **The Hospital Anxiety and Depression Scale (HADS)**<sup>371</sup> is a self-assessment scale of 14 items designed to measure anxiety and depression. It has a high face and concurrent validity; and internal consistency. Odd-numbered questions assess anxiety while even-numbered

assess depression. Each question has 4 response options and can be scored on a scale from 0 to 3. The maximum score is, therefore, 21 each for anxiety and depression. A total score of 8 to 10 being suggestive of depressive/anxiety disorder with a score of 11 or higher indicate the probable presence of the respective state. The anxiety and depression subscales have been found to be independent measures.

11.4.4.2      **The Bradford Somatic Inventory (BSI)**<sup>372</sup> is used to measure somatic symptoms. A widely used Urdu version, developed in South Asia, is available, having 46 items. Scores above 21 indicate depression. The BSI investigates about somatic symptoms during the previous month, and if there is a positive response to a question, whether the symptom has occurred on more or less than 15 days during the month (scoring 2 or 1, respectively).

11.4.4.3      **WHO Disability Assessment Scale (WHO DAS 2.0)** is a new version of BDQ<sup>373, 374</sup> and was developed by WHO to measure disability as a result of physical and/or psychological problems.

11.4.4.4      **Schwartz Outcome Scale (SOS)** was developed at Department of Psychiatry, Massachusetts General Hospital<sup>375</sup>. It is a low

burden measure, developed to monitor outcome (satisfaction), across a wide range of adult mental health services.

All these scales, except Schwartz Outcome Scale have already been used in various studies in Pakistan. A proforma was used to collect demographic information from the client.

#### **11.4.5 Drop outs**

Participants who attended 3 or less than 3 sessions in the intervention arm were considered to have dropped out from the therapy. For TAU arm, participant who did not report back for follow up assessment were considered drop outs. Three participant from the CaCBT plus TAU and Four from TAU group were drop outs. Among the drop outs, two patients attended only one session and one attended 3 sessions. So they were considered drop outs.

#### **11.4.6 CBT Intervention**

CBT was provided to all the participants in the study arm using the manual prepared before this study in addition to Treatment as Usual (Prescription of Antidepressants). The manual developed in Pashto, for this study, consisted of details of therapy in short chapters, along with detailed patient information leaflets for each session. Appendices also contain samples of

thought diaries and behaviour activity charts. Additionally, the provision of relevant questions for each technique makes things easy for the new therapist.

A brief version of therapy was used involving 6 sessions with a follow up session for assessment. All patients were reminded to attend their sessions a day earlier via mobile phones. The patients were encouraged to attend even if they were unable to complete their homework. One attended 5 sessions and the rest 16 attended 6 sessions and were included in the study. During the therapy sessions a family member accompanied the patient and helped the patient in completing their homework, if required. Two of the patients in the intervention arm did not come for follow up assessment and they were contacted over phone and follow up assessments were arranged at home.

#### 11.4.6.1 **Arrangement of sessions**

**Session 1:** Introduction, assessment and formulation; Information regarding therapy plan and CMDs as well as anxiety management if anxiety symptoms are prominent.

**Session 2:** Thought and its link with mood and behaviour; emotions and their recognition

**Session 3:** Challenging negative automatic thoughts; Teaching and evaluation regarding cognitive errors

*Session 4:* Talking about creating alternate thoughts;

*Session 5:* Problem solving

*Session 6:* Use of behavioural methods for example, activity scheduling; guidance on Staying well; Closure work

#### **11.4.7 Treatment as Usual (TAU)**

The TAU group received the treatment delivered by the consultant psychiatrist in their routine practice which usually consists of prescription of antidepressants. These patients were generally followed up every 4 weeks. Out of 20, 16 came for follow up assessment of the trial. At the time of the final assessment, the participants of this group were given the option of receiving CaCBT.

#### **11.4.8 Outcomes and Assessments**

Assessments were carried out at baseline and at the end of therapy (7-11 weeks). All the scales that were used at baseline were filled again. Only Schwartz outcome scale, which is a scale to monitor outcome, was filled at follow up.

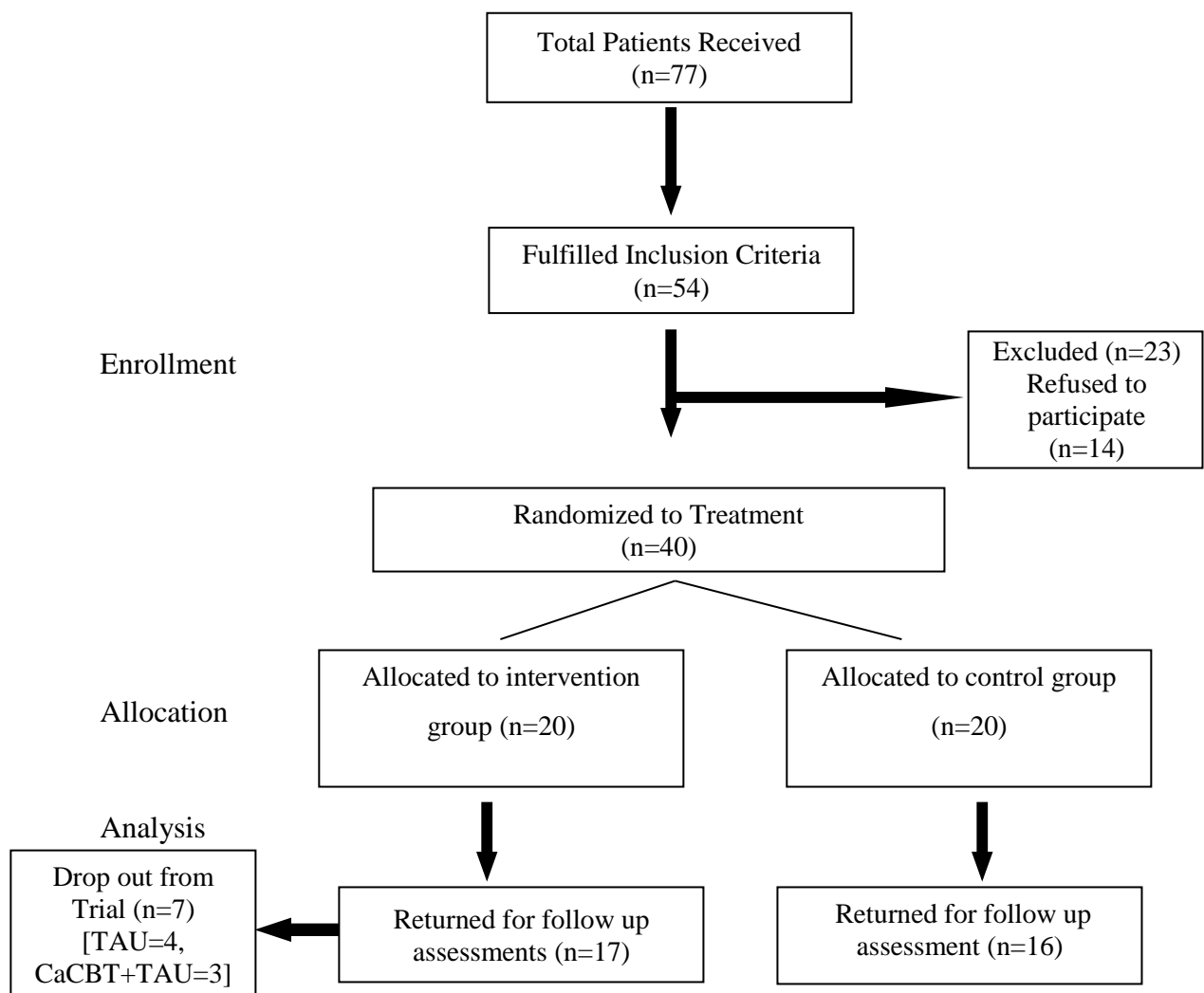
### **11.5 Statistical Analysis**

Following the CONSORT guidelines for randomized controlled trials<sup>376</sup>, the analysis was carried out using SPSS version 20.0 on intention to treat basis.

Analyses to compare the demographics of two groups were carried out using chi square test (to compare gender, marital status, occupation, clinical diagnosis, drug abuse and previously received non pharmacological intervention) and t test (for age and education). A linear regression analysis was used, with end of therapy as the dependent variable and group allocation and baseline differences scores as independent variables.

Figure 11.1 shows the consort flow diagram.

**Figure 11.1: CONSORT Flow diagram of CBT Pashto Trial**





## 11.6 Ethical Approval

The study received ethical approval both from Ethical Committee of FCM-New University of Lisbon and Prime Foundation Peshawar.

## 11.7 Results

The mean age of the sample was  $31.08 \pm 9.89$  years. Out of 40 patients, 27 (67.5%) were females. Most of the patients were married ( $n = 21$ , 52.5%). There were 4 (10%) Afghani participants in the trial. The majority of the sample was house wife/ lady ( $n=18$ , 45%). Except 4, all were educated (primary or above). Depression alone or combined with other psychiatric illnesses made the biggest diagnostic group ( $n=38$ , 95%). Only one (2.5%) was using Injectable Pentazocine. Nine (22.5%) were receiving or had already received non-pharmacological treatment in the past. Out of 40 patients assigned for trial, 33 patients came for follow-up sessions which makes it 82.5%. Further demographic details are given in table 11.1.

**Table 11.1:** Demographic Details ( $n=40$ )

Variable		Frequency	Percent
Gender	Male	13	32.5
	Female	27	67.5
Marital Status	Single	16	40
	Married	21	52.5

	Widow	2	5.0
	Separated/Divorce	1	2.5
Nationality	Pakistani	36	90
	Afghans	4	10
Occupation	House Lady/ House Wife	18	45
	Unemployed (Student)	7	17.5
	Self Employed (Business man/ woman)	5	12.5
	Employed - Health care Staff (Doctor, Nurse, Anesthesia Technician)	4	10
	Employed - Others (Labourer, Manager, Orderly, School teacher, Shift In charge, Computer Operator)	6	15
Educational Status	Uneducated	4	10.0
	Primary	8	20.0
	Secondary	15	37.5
	Graduation	4	10.0
	Post graduation	9	22.5
Clinical Diagnosis	Depression	23	57.5
	Anxiety	2	5.0
	Depression & Anxiety	12	30.0

	Depression & Personality Issues	2	5.0
	Depression, Anxiety & Personality Issues	1	2.5
Drug Abuse	Yes	1	2.5
	No	39	97.5
Already received non Pharmacological Intervention	Yes	9	22.5
	No	31	77.5

Twenty patients were assigned to each arm of the trial, i.e., 20 in Intervention (CaCBT+TAU) and 20 in control (TAU). There were no statistical differences between the two groups at baseline. The level of significance of Age and Education (in number of years) was measured using t test while the rest were measured using chi square test. The details are given in table 11.2.

**Table 11.2:** Differences in demographic variables and psychopathology between the intervention and the control groups at the baseline, where figures are number (mean) SD for age and education, while the rest are number (%).

Variable	TAU (Control group)	CaCBT + TAU (Intervention Group)	P*
Gender (Male)	3 (15%)	10 (50%)	.020
Age	20 (29.90) 8.25	20 (32.25) 11.40	.459
Education (In number of years)	20 (7.75)4.48	20 (11.65) 4.93	.013
Marital Status			
Single	7 (35%)	9(45%)	.348
Married	10 (50%)	11(55%)	
Widow	2 (10%)	0 (0%)	
Separated/Divorce	1(5%)	0 (0%)	
Occupation			
House Wife/ House Lady	12 (60%)	6 (30%)	.166
Unemployed (Student)	2 (10%)	5 (25%)	
Employed (Healthcare Staff and Others)	5(25%)	5 (25%)	
Self-employed (Business man/ woman)	1 (5%)	4 (20%)	
Clinical Diagnosis			
Depression	14 (70%)	9 (45%)	.247
Anxiety	1 (5%)	1 (5%)	
Depression & Anxiety	4(20%)	8 (40%)	

Depression & personality issues	0	2 (10%)	
Depression & anxiety & personality	1 (5%)	0 (0%)	
<b>Drug Abuse</b> (yes)	1 (5%)	0 (0%)	.500
<b>Already received non Pharmacological Intervention</b> (yes)	4 (20%)	5 (25%)	.500

\*p values using t test for age, education and Chi square for the rest

There was no statistically significant difference between the two groups on baseline [i.e., HADS-Anxiety Subscale, HADS–Depression Subscale, BSI and WHO DAS 2.0. Further details are given in table 11.3.

**Table 11.3:** Difference between the scales used in two groups on baseline using t test

Variables	Group	n	Mean	SD	P
HADS (ANXIETY)	CaCBT+TAU	20	10.85	3.660	.459
	TAU	20	11.70	3.526	
HADS (DEPRESSION)	CaCBT+TAU	20	12.50	2.947	.528
	TAU	20	13.30	4.780	
BSI	CaCBT+TAU	20	30.10	15.980	.065
	TAU	20	39.95	16.757	
WHO DAS 2.0	CaCBT+TAU	20	19.95	11.705	.950
	TAU	20	20.15	8.203	

Final outcome assessment showed a statistically significant reduction in all the scores in intervention group as compared to the control group. Schwartz Outcome scale also showed better satisfaction with treatment in the intervention group (Table 11.4).

**Table 11.4:** Differences between the intervention and control groups, both uncontrolled and controlled for baseline differences. Analyses were carried out using a linear regression. Reduction in scores means improvement.

	Differences uncontrolled				Differences controlled for baseline	
	TAU (Control Group) Mean (SD) [n=16]	CaCBT+TAU (Intervention Group) Mean (SD) [n=17]	Mean difference (CI)	P*	Mean difference (CI)	P*
HADS Anxiety	10.38(4.15)	4.71(2.69)	4.93 (8.134,3.204)	0.000	0.646 (.769,.123)	0.008
HADS Depression	10.38(5.23)	3.94(4.58)	6.964 (9.916, 2.952)	0.001	0.757 (1.029,.272)	0.001
BSI	33.75(16.53)	9.18(7.80)	18.177 (33.662,15.485)	0.000	0.478 (.724, .281)	0.000

WHO DAS 2.0	21.44(8.88)	9.71(9.40)	13.001 (18.232, 5.231)	0.001	0.576 (.822, .246)	0.001
SOS	30.31(12.27)	44.53(10.45)	-16.15 (-6.142,-22.292)	0.001	-	-

\*p values were obtained using linear regression.

## 11.8 Discussion

There are socio-cultural and health system barriers faced by residents of the region under study. Overcoming these barriers through specific management strategies, along with increasing awareness and improving recognition of CMD, can prove to be beneficial. The intervention used in this study, although based on CBT used in Western society, was successfully modified using necessary conceptual, format and delivery modifications, as per our culture, to improve compliance with therapy and thus symptom reduction. More participants in the intervention group were still taking antidepressant medication by the end of the therapy as compared to the control group. This disparity in medication use is likely to contribute to better outcomes in the intervention group.

In our trial, females were more in number which is a known fact that females suffer more from CMDs<sup>377, 378</sup>. The majority of our participants were married which is contrary to the usual findings<sup>379</sup>. However, with the

small sample size, this cannot be considered generalizable. The most CMD was reported to be depression which is in line with the current literature<sup>380, 381</sup>. Our sample showed that more than three fourths were either not aware or were not receiving psychotherapy. This can be seen in the context of our qualitative work and as reported in other studies from the region where patients are more interested in pharmacotherapy and the opportunities for psychotherapy are lacking<sup>382</sup>.

Psychometric tools are used for measuring the outcome in patients with CMDs. HADS has been used to measure the symptoms of anxiety and depression separately<sup>383, 384</sup>. In our study, we felt that the results of the scale could be seen comparable to clinical findings. Our findings of HADS are in line with the findings of other studies<sup>385, 297</sup>. In the study by Farooq et al, participants in treatment group showed statistically significant improvement in both depression ( $p=0.000$ ) and anxiety ( $p=0.000$ ) on HADS<sup>297</sup>.

In the south Asian region, psychiatric symptoms are expressed in somatic terms<sup>386, 387</sup>. Somatic symptoms for CMDs are common<sup>388</sup>. We used BSI to find the somatic symptomatology in those suffering from CMDs and found that there were more symptoms/ score at baseline compared to follow up showing that more the depression/ anxiety, more is the somatic content. This is similar to other studies<sup>389, 297</sup>. In the study by Farooq et al,



participants in treatment group showed statistically significant improvement in somatic symptoms ( $p=0.005$ ) measured on BSI<sup>297</sup>.

Disability is closely associated with all psychiatric illnesses including CMDs<sup>390</sup>. WHO DAS 2.0 was used to measure this in our study. It was noted that there was decrease in psychological and physical disability associated with improvement in the level of depression and anxiety which is in line with the findings of other studies<sup>80, 297</sup>. In the study by Farooq et al, participants in treatment group showed statistically significant improvement in disability ( $p=0.000$ ) measured on BDQ, which was the older version of WHO DAS<sup>297</sup>.

Schwartz Outcome Scale was used to measure the satisfaction with the treatment<sup>391, 392</sup>. Scores in experimental treatment were higher than TAU. This satisfaction has been reported in other studies<sup>297, 393</sup>. In the study by Farooq et al, participants in intervention group reported more satisfaction with treatment as compared to control group<sup>297</sup>.

Cost-effectiveness, quality of life, and changes in cognitive errors and beliefs need to be assessed in future researches.

### **11.9 Limitations of the Study**

This was just a pilot project with small number of participants and many variables which could potentially influence therapy were not studied e.g., close contact with therapists and increased compliance with antidepressants, might have led to significant improvement in the intervention group.

### **11.10 Conclusions**

In conclusion, CaCBT in Pashto using a culturally adapted CBT manual was successful in reducing the core symptoms of CMDs, along with somatic symptoms, and disability.

## **CHAPTER 12: SUMMARY & WAY FORWARD**

We have discussed the main findings of each study at the end of each chapter. We will therefore only summarize the qualitative and quantitative findings and the relevant points from the discussion as well as the points that were not covered during discussion of the individual chapters. As this is a new area in psychotherapy there are many questions unanswered. We became acutely aware of this as we went through the content of this thesis. We hope that it can be a good contribution to this new area in psychotherapy. We tentatively call it study of CBT across cultures or “ethno-CBT”, a term already used by our group<sup>21</sup>.

We set out to adapt CBT with an understanding that, in addition to usual barriers, cultural barriers (language included) need to be overcome when a psychological intervention like CBT (originated in the west) is adapted.

There were two aims of this project, first to adapt CBT, and the second to draw some general principles for a methodology. Here we will summarize and describe some of the generalized points and the lessons learned:

1. The process of the adaptation should involve all the stake holders (providers and recipients of the therapy), and a greater emphasis should be put on understanding the health systems.

2. We started with a loose framework. We were willing to learn as we went along.
3. Mixed methods research can be a powerful tool when developing interventions in areas where no such work has been done.
4. Initial work helped to develop questions rather than answers: e.g., what do patients think about psychotherapy, what do professionals think are the issues in providing therapy and what do people think about CBT.
5. It is important to develop a strategy for translation which involved members of the general public.
6. Culturally sensitive communication styles and power issues should be utilized.
7. Strategies to engage patients (for example involving a family member in therapy) are effective.
8. Adaptation can be done through a series of small scale studies and does not need to be a time-consuming and costly affair.

### **12.1 Interviews with patients**

We believed that understanding patients' perspective (what do they consider regarding their illness, risk factors, causes, treatment and specially psychotherapy) is really important in this regard. Therefore, these interviews helped us in getting relevant information. We asked about, the common symptoms of their illness, their understanding about common

mental disorders (CMDs), their knowledge about treatment of their condition, experience of visiting non-mental health professionals, their common beliefs about causes or treatment of their illness, their view of the role of the mental health professionals; their expectations from psychiatrists/doctors, their knowledge about psychologists and their role, their knowledge about psychotherapy and its effect, their thoughts about medication, and their thoughts on the effect of illness on their lives.

Our impression was that when a controversial topic was discussed (for example about help from faith healers) patients were guarded and tried to give an answer which they felt was the answer we want to hear. Six key themes emerged from the analysis of data which related to their: (1) perception of illness and its impact on their lives; (2) model of causes of their illness; (3) model of referral; (4) treatment of illness; and pertaining to *general knowledge about mental illnesses*; (5) knowledge and perception of psychiatric illnesses; and (6) treatments of these psychiatric illnesses.

Most patients were not aware of the names of the illnesses. Patients complained of physical symptoms a lot. All the patients were of the opinion that their illness has affected their lives but told that they had to work to survive. Most of them described social problems, problems at home and work to be the cause of the illness. Ten were referred by a family member.

All of them believed that they can get better with medicines and three of them considered psychotherapy to be a valid treatment option as well. When asked about their perception of mental illness in general, everyone, except four, had at least a vague idea about it and all of them believed that mental illnesses are treated by medications and were guarded when talking about other treatments, especially non-medical treatments.

## **12.2 Interviews with carers**

We believed that understanding carers' perspective (what do they think about the illness of their patient, its causes, its treatment and specially psychotherapy) is really important in this regard. Therefore, these interviews helped us in getting relevant information. We asked similar questions that we asked from the patients and tried to look at their perspective. Similarly, six themes emerged from these interviews, as mentioned under 12.1.

No one knew the exact diagnosis of their patients or about the nature of the illness of their patients. However, they admitted that the illness has affected the lives of patients and family members/ carers. Most of the carers reported that they themselves brought their patients to psychiatric service. All believed that their patient can get better with medicines. Although fourteen told about their visit to Religious Scholar. Carers did not had adequate

knowledge about mental illness but believed that mental illnesses are treated by medications.

### **12.3 Interview with mental health professionals**

We thought that talking to professionals would give us initial information as well as guidelines for our work. We simply wanted to see what their experience of treating clients with depressive illness was, and how we could learn from that in order to adapt therapy in Pakistan. We made a list of topics and conducted interviews to gather information in those areas. We contacted mental health professionals working in Peshawar, Pakistan. Areas explored during the interviews included, background of the mental health professional, the usual patient load that they have and the proportion of those who suffer from CMDs, the details of therapy sessions including attendance and attrition of clients, understanding of Western psychotherapy techniques, effective and helpful therapeutic techniques, Patients' expectations of therapists, the role of the family and community, need to modify CBT techniques for use in our region and if so, how, and the barriers providing these treatments and how they overcome these barriers.

The themes and the sub themes generated were the following: Issues related to pre therapy situation (Service issues; Dealing with somatic complaints; Pharmacotherapy and psychotherapy; Homework; Patient's expectations

from mental health professionals; and Literal translation does not work); Issues related to therapy (Assessment; Structure and content of sessions; Commonly used techniques; and Techniques which patients find helpful); Style of therapy; Involvement of the family; Barriers in psychotherapy; and Differences in therapy.

They felt that health system has failed on so many levels including generating financial and human resources, balancing the load of patients and the availability of qualified mental health professionals. They reported that most patients present with somatic symptoms. We therefore emphasized focusing on somatic complaints at the start of therapy. The professionals described that patients were more interested in medicines. They were of the opinion that patients are not keen on doing the homework given as part of therapy. Mental health professionals told that word for word translation does not work and it is difficult for them to explain even the basic terms and when they try to inform patients that it is a talking therapy, patients consider it to be useless. Mental health professionals describe assessment as a crucial part of the whole process. They were of the opinion that following a structured session style is not always possible but usually everything starts with assessment. They frequently report using Problem Solving, cognitive restructuring, and relaxation techniques. They thought that patients considered cognitive restructuring, relaxation and reattribution to be more



effective than other techniques. Mental health professionals were of the opinion that the patients want to have their advice and expectation but they try to be collaborative. All of them thought that it is important to involve the family in the therapy because this decreases the chances of drop out from the therapy, especially in the case of female patients. All of them believed that there is a considerable difference in the therapy done here as compared to the west.

#### **12.4 Discussion with Students**

It is possible that students do not reflect views held by wider societies but, during the course of this study, it was revealed that one of the barriers in therapy is unavailability of properly translated reading material and terminology in Pashto is one of the barriers. It was felt that, for terminology to be effective, it should be grounded in locally used idioms and expressions. The “Name the title” technique proved to be useful in finding alternatives for cognitive errors and other relevant terminologies in this study. Patients found the terminology generated as a result of this exercise, easy to understand and to remember.

#### **12.5 Pilot project: CBT in Pashto for CMD**

After the qualitative studies, we decided to conduct the pilot project of CBT in Pashto for CMDs. Twenty patients were assigned to each arm of the trial,

i.e., 20 in Intervention (CaCBT+TAU) and 20 in control (TAU). There was no statistically significant difference between the two groups on baseline [i.e., Demographics, HADS-Anxiety Subscale, HADS–Depression Subscale, BSI and WHO DAS 2.0]. Final outcome assessment showed a statistically significant reduction in all the scores in intervention group as compared to the control group. Schwartz Outcome scale also showed better satisfaction with treatment in the intervention group.

## **12.6 Lessons learnt**

Our project aimed at adapting CBT in Pashto for a non-Western culture in Pakistan and Afghanistan. The methodology we adopted was successful in developing an adapted version of CBT in Pashto. Our project consisted of a series of small studies. The main point that our work highlights is that involving patients, carers and mental health professionals/therapists in the process of adaptation of the therapy is essential, and should be preferred in comparison with attempts to adapt CBT in a given culture. This adaptation process can be easily carried out through small scale qualitative studies which focus relevant populations. The adaptation process can be divided into these steps: (1) gathering information; (2) developing a framework which might provide guidelines for adaptation; (3) adaptation of a CBT manual; (4) testing of a manual in a pilot trial; (5) further refinement of the manual; (6) testing of the manual in a RCT. A small pilot project, done at

the end (as mentioned), found the therapy to be effective.

## **12.7 Way Forward**

The need of active participation of the recipients during psychological interventions is of paramount importance as compared to physical treatment where passive involvement is often enough. It is therefore important that we study not only their explanatory models of the disease, but also study attitudes of health professionals as well as related issues in society. On the other hand, non-Western cultures have developed their own ways of managing emotional problems over the centuries. We were not able to explore the local practices of dealing with mental health problems and this can be considered as a major limitation. Cultural diversity is another area that needs consideration here. The diversity of cultures and languages might not be impossible to manage in the Western world. There is, however, more diversity of cultures and associated languages in Asia and Africa and therefore simple translations might not work.

Similar studies are required in Pakistan to adapt therapy for other disorders. The therapy we adapted needs to be tested in a bigger trial and further modifications made if required. Similarly, adaptation work in other countries will also give us more insights into cultural differences and their impact on therapy and its adaptation.

## **ANNEXURES**

### *1. Scales used in pilot project*

- a. Hospital Anxiety and Depression Scale (HADS)*
- b. Bradford Somatic Inventory (BSI)*
- c. World Health Organization - Disability Assessment Scale (WHO DAS 2.0)*
- d. Schwartz Outcome scale (SOS)*

### *2. Consent forms*

- a. Consent form for patients*
- b. Consent form for carers*
- c. Consent form for professionals*
- d. Consent form for students*

## “Hospital Anxiety and Depression Scale (HADS)”

ہاسپٹل اینگزائٹی او ڈپریشن سکیل

نمبر شمار	احساسات	تقریباً بر وخت	اکثر وختوں کب	کلہ کلہ	بالکل نہ
1	زہ دہ مزغو سترے والے او بوجھ محسوسہ ووم۔				
2	کم سیزونہ چہ بہ مخکین زما خواخ وہ اوس ہم اغہ زما خواخیگی۔				
3	ماتہ داسے لگی چہ سہ خرابہ یا خطرناکہ خبرہ کیدو والا دہ۔				
4	ماتہ چہ دہ ٹوکو سہ خبرہ اوشی نو مالہ خندا رازی۔				
5	زما پہ ذہن کبیں دہ پریشانی خبرے رازی				
6	زہ خوشحالی محسوسہ ولے شم				
7	زہ پہ آرام سرہ کیناستے شم او سکون محسوسہ ولے شم				
8	ماتہ خکاری چہ دہ مخکین پہ نسبت زہ سست شوے یم				
9	بغیر دہ سہ وجے نہ زہ یرا محسوسوم او دہ اغے پہ وجہ زما پہ خیٹہ کبیں دڑ شی				
10	ما دہ ذان خیال سائل پریخودل				
11	زہ بے قرار ہ اوسم او پہ کلارہ سرہ نہ شم کیناستے				
12	زہ دہ راتلونکو واقعاتوں پہ خوشحالی اور اطمینان سرہ انتظار کوم				
13	زہ یم دم ڈیر زیات گھبراؤ شم				
14	زہ دہ یو خہ کتاب، ریڈیو یا ٹی وی پروگرام نہ خواند اخلم				

## “Bradford Somatic Inventory (BSI)”

بریڈفورڈ سوماتک انوینٹری

نمبر شمار	تیرہ شوے میش کیں	غیر موجود	تیرہ میش کیں پینزلسو ورزو نہ زیاتو کیں موجود اوہ
1	آیاستاسو پہ سر درد شوے اوہ؟		
2	آیا ستاسو پہ معدہ کیں سہ گھبراہٹ یا سہ داسے سیز چہ خوازی محسوسہ کڑے مودہ؟		
3	ستاسو پہ ولو یا سٹ کیں درد یا سٹڑے والے راغلے اوہ؟		
4	آیا ستاسو ٹول بدن سوازیڈو یا خارخ پہ لگے دلے وی؟		
5	آیا تہ دا محسوس کوے چہ چا ستا دہ سر کلک نولی دی؟		
6	تاسو پہ سینہ یا زڑہ کیں سہ درد غوندے محسوس کڑے دے؟		
7	تاسو خپلہ خلہ یا مرائے کلہ اوچھ محسوسہ کڑے دہ؟		
8	ستاسو دہ سترگو وڑاندے سہ تیارہ او یا سہ دھند غوندے راغلے اوہ؟		
9	تاسو پہ معدے کے سہ سوزے محسوس کڑے اوہ؟		
10	تاسو تہ خو خپل دان کمزورے نہ خکاری؟		
11	تاسو پہ خپل سر کیں خو گرمی یا سوزے نہ محسوسہ ولو؟		
12	تاسو باندے خوالہ زیاتہ راتلہ؟		
13	تاسو تہ خو داسے نہ لگیدہ چہ ستاسو زڑہ یا		

			سینہ باندے سہ بوجھ دے؟	
14			ستاسو پہ خیتا کبں درد اوہ یا بے آرامہ وے؟	
15			تاسو تہ دا محسوسہ شوے وہ چہ ستاسو مرائی کبں سا اودرے دہ؟	
16			ستاسو خپے لاسونہ از غی یا اوہ شوے خو نہ دی؟	
17			ستاسو ٹول بدن سترے سترے یا دڑمند خو نہ اوہ؟	
18			تاسو پہ خپل بدن کبں گرمی محسوسہ کڑے وہ؟	
19			تاسو تہ خو داسے نہ محسوس کیدہ چہ ستاسو زڑہ زر زر درازیگی؟	
20			تاسو پہ خپلو سترگو کبں درد یا سوزے محسوس کڑے اوہ؟	
21			تاسو تہ بدبضمی تکلیف وہ؟	
22			تاسو باندے یخنی اوہ رپیدل خو نہ وہ راغلی؟	
23			تاسو لہ اودس ماتے/میتیا زے خو بار بار نہ راتلے؟	
24			تاسو تہ پہ ملاء کبں دہ درد شکایت خو نہ اوہ شوے؟	
25			تاسو تہ دہ خو نہ وہ محسوس شوے چہ خیتہ پڑسیدلے یا زوڑندہ غوندے دہ؟	
26			ستاسو سر خو دروند شوے نہ اوہ؟	
27			تاسو بہ چہ کار نہ کولو نو ہم بہ مو سترے والے محسوس کولو؟	
28			تاسو بہ چہ کار نہ کولو نو ہم بہ مو خپے خوگیدلے؟	
29			تاسو تہ بہ زڑہ کچا کیدو؟	

30	تاسو ته به دا لگیده چه ستاسو سر شلیگی؟		
31	تاسو ته به ده خوب په وخت کېن هم ده سا اغتو تکلیف اوه؟		
32	تاسو به په ټول بدن کېن داسه محسوس کوله چه ستته درکېن سوک ټوښی؟		
33	تاسو ته به ده قبض شکایت وه؟		
34	تاسو خو به باربار اودس ماتی له نه تلی؟		
35	ستاسو لاسونو به ټیر خواله کیدل؟		
36	تاسو خوراک داسه تیرولو لکا چه یو کوله ده مرائی نه خکته کیگی؟		
37	ستاسو په سر باندې چکر و غیره به راتلو؟		
38	ستاسو ده خله خواند خو تریخ شوه نه وه؟		
39	تاسو خو ټول بدن داسه دوروند غوندې نه محسوس کولو؟		
40	تاسو چه مو تیا زه کولې نو سوزې دے خو نه؟		
41	ستاسو په سر او غواگونو کېن شنگار خو نه کیدو؟		
42	ستاسو زړه خو ټوپیډو نه او کمزوری خو مو نه محسوسه وله؟		
43	ستا سو په گیډه کېن کیس وه یا اکرهمی به مو زیات کول؟		
44	ستاسو لاسونه او خپه به یخه شوه؟		
	<b>صرف سړو ده پاره:</b>		
45	تاسو ته داسه شوه اوه چه شوق مو نه اوجتیدو؟		
46	تاسو محسوسه کړه وه چه مو تیا زو کې منی خارج شوه وی؟		



**“WORLD HEALTH ORGANIZATION, DISABILITY  
ASSESSMENT SCHEDULE 2.0 (WHO DAS 2.0)”**

دېليو ايچ او، ډس ايبيليټي اسيمنټ شېډول 2.0

تير شوؤ 30 ورځو کېن تاسو ته سمرامشکل وؤپه دے هر سه کېن	بالکل نه	لږشان	مناسب حده پوري	ډير زيات	ډير نه شم کولي
S1					ډير وخت پوري ودریدو کېن مثلاً ۳۰ منټ پوري ودریدو کېن
S2					ده کور نه مه واري پوره کولو کېن
S3					سه نوے کار ایزدا کولو کېن مثلاً چرته نوئي زئي ته تللو کېن
S4					په معاشرتي تقریبات کېن (غم، خادي يا بل سه پروگرام وغيره) که شاملیدو کېن تاسو ته سومره مشکل وؤ؟ مثلاً میلا وغيره يا
S5					د خپل صحت په حق له تاسو جذباتي طور باندي سمر متاثره شوي یئي؟
S6					سه کار 10 منټ پوري پوره توجه سره کولو کېن
S7					لري پوري پیدل تللو کېن مثلاً 1 کلو میتر پوري پیدل تللو کېن
S8					لامبلو کېن
S9					کپرو بدلاولو کېن/ تیاریدو کېن
S10					د هغه خلقوسره خبري کولو کېن چي تاسو نه پیژني
S11					خپله ملگرتيا قائمه ساتلو کېن
S12					روزانه کار کولو کېن يا سکول ته په تلوکېن

H1	مجموعي طور باندې/يا سرپټوله د مشكلات تير شوي ميشت کين سو ورځو پوري تاسو ته وؤ	ده ورځو شمير ريكارډ كني _____
H2	تير شوي يوې ميشت په دوران كين سوورځو پوري خپل صحت دوجه تاسو د خپل روزانه كارونو كولو قابل نه وئي	ده ورځو شمير ريكارډ كني _____
H3	تير شوي ۳۰ ورځو كين ده هغه ورځو نه علاوه چه تاسو بالكل ده كار قابل نه وئ، تاسو سومره ورځه ده صحت مسئلو په وجه خپل كارونه كم كړي دي.	ده ورځو شمير ريكارډ كني _____

## “Schwartz Outcome Scale-10”

شوارتز آؤٹ کم سکیل

ہدایات: لاندنی ورکڑی شوی سوالونوں جواب ورکڑی پہ تیرہ ہفتہ کبں پہ تاسو سہ تیر شوی دی۔ ستا سو پہ ذہن کبں چہ ژومبے جواب راشی بس هُم بغہ بہ ستا سو جواب وی۔ ده دے سوالونوں سہ صحیح یا غلط جواب نہ وی۔ تاسو پہ یو خانہ کہ نخہ اولگوئی۔

سوال نامہ	0	1	2	3	4	5	6
1. موجودہ جسمانی حالت کبں چہ زہ سہ کوم بغے باندے مطمئن یم	ہس کلہ نہ						ہر وخت او کہ اکثر اوقات
2. زما پہ دان یقین دے چہ زہ خپل تعلقات خہ طریقے سرہ برقرار ساتلے شم							
3. زہ ده خپل مستقبل بارہ کبں پر امید یم							
4. زہ اکثر خپل کارونو کبں دلچسپی او جوش لرم							
5. زہ ده لطف اندوز کید و صلاحیت لرم							
6. زہ ده خپل نفسیاتی صحت نہ مطمئن یم							
7. زہ خپل ناکاموں باندے دان معاف کولے شم							
8. زما چوند زما ده توقعا تو مطابق روان دے							
9. خلقو سرہ اختلافات زہ پخپلہ حل کولے شم							
10. ماتہ ذہنی سکون شتہ							

## CONSENT FORM FOR PATIENTS

Title: **DEVELOPING & TESTING OF CULTURALLY ADAPTED  
CBT (CaCBT) FOR PASHTO SPEAKING PAKISTANIS AND  
AFGHANS**

Study Number:  
Ethics Number:

Version number: 1  
Dated:

Please check the box

“I confirm that I have read and understand the information sheet, for the above study, and have had the opportunity to ask questions.

☐

I understand that my participation is voluntary and that I am free to withdraw from the study at any time, without giving any reason, without my medical care or legal rights being affected.

☐

I agree to take part in the above study.

☐

Name of Patient

Signature

Date

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Name of Person  
taking consent  
(if different from researcher)

Signature

Date

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

1 for Patient, 1 for Researcher”

## CONSENT FORM FOR CARERS

Title: **DEVELOPING & TESTING OF CULTURALLY ADAPTED  
CBT (CaCBT) FOR PASHTO SPEAKING PAKISTANIS AND  
AFGHANS**

Study Number:  
Ethics Number:

Version number: 1  
Dated:

Please check the box

"I confirm that I have read and understand the information sheet, for the above study, and have had the opportunity to ask questions.

☐

I understand that my participation is voluntary and that I am free to withdraw from the study at any time, without giving any reason, without my (and my patient's) medical care or legal rights being affected.

☐

I agree to take part in the above study.

☐

Name of Carer

Signature

Date

\_\_\_\_\_

\_\_\_\_\_

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Name of Person  
taking consent  
(if different from researcher)

Signature

Date

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

1 for Carer, 1 for Researcher"

## CONSENT FORM FOR MENTAL HEALTH PROFESSIONALS

Title: **DEVELOPING & TESTING OF CULTURALLY ADAPTED CBT (CaCBT) FOR PASHTO SPEAKING PAKISTANIS AND AFGHANS**

Study Number:  
Ethics Number:

Version number: 1  
Dated:

Please check the box

“I confirm that I have read and understand the information sheet, for the above study, and have had the opportunity to ask questions.

☐

I understand that my participation is voluntary and that I am free to withdraw from the study at any time, without giving any reason, without my legal rights being affected.

☐

I agree to take part in the above study.

☐

Name of Mental Health Professional	Signature	Date
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\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Name of Person  
taking consent  
(if different from researcher)

Signature

Date

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

1 for Mental Health Professional, 1 for researcher”

## CONSENT FORM FOR STUDENTS

Title: **DEVELOPING & TESTING OF CULTURALLY ADAPTED CBT (CaCBT) FOR PASHTO SPEAKING PAKISTANIS AND AFGHANS**

Study Number:  
Ethics Number:

Version number: 1  
Dated:

Please check the box

“I confirm that I have read and understand the information sheet, for the  
above study, and have had the opportunity to ask questions.

☐

I understand that my participation is voluntary and that I am free to  
withdraw from the study at any time, without giving any reason, without my  
legal rights being affected.

☐

I agree to take part in the above study.

☐

Name of Student

Signature

Date

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Name of Person  
taking consent  
(if different from researcher)

Signature

Date

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

1 for Student, 1 for researcher”

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